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An investigation of some principles, problems, and techniques of music therapy and the place of music in the rehabilitation program at Sonoma State Hospital

Nicholas S. Mallek
University of the Pacific

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AN INVESTIGATION OF SOME PRINCIPLES, PROBLEMS, AND
TECHNIQUES OF MUSIC THERAPY AND THE PLACE OF MUSIC
IN THE REHABILITATION PROGRAM AT
SONOMA STATE HOSPITAL

A Thesis
Presented to
the Faculty of the Graduate School
College of the Pacific

In Partial Fulfillment
of the Requirements for the Degree
Master of Arts

by
Nicholas S. Mallek
June 1959

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In sincere appreciation for the trust and confidence she has continued to place in me, this work is dedicated to Mrs. Wilhelmina K. Harbert.

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CHAPTER I

THE PROBLEM AND DEFINITIONS OF TERMS USED

(A great many people have felt the need for more research and investigation in the field of music therapy,) with special emphasis on the use of music with the mentally deficient and/or physically limited child. (A great deal of literature dealing with music and its manifestations in regard to the mentally ill has been published and circulated to both professional organizations and laymen,) but the contribution in this field dealing with music and the mentally deficient, has been considerably less. It would seem that such research would contribute invaluable data in establishing music as a vital factor in therapeutic rehabilitation, and in clarifying the scope and role of music therapy in the hospital and community as well. A critical and exhaustive investigation on the hospital level could aid in determining the worth and value of music as an universal tool and medium in social adjustment. More important, such an investigation could establish a clarity of language, thought, and rationale in regard to the principles, methods, and problems of music in an institution where music plays a role in therapy and rehabilitation.

I. THE PROBLEM

Statement of the problem. (It is the purpose of

this study (1) to discover the nature, history, and present day use of music in therapy; (2) to discover the types of patients at Sonoma State Hospital and their general needs in terms of rehabilitation services; (3) to discover the scope of the total rehabilitation program at Sonoma State Hospital and the part which music therapy plays; and (4) to discover the general principles, problems and techniques of music therapy used at Sonoma State Hospital.)

Importance of the study. (In the State of California, at the present time, there are eleven hospitals for the mentally ill, three hospitals for the mentally retarded (with one more under construction), (and seven state mental hygiene clinics.) Even within each of the three hospitals, as individual institutions, there are differences of opinion as to the role of music in therapy. The scope and purpose of music in therapy may differ even among the existing institutions, and those individuals involved directly with the program are still seeking answers to the many unsolved problems. It is the aim and desire of the writer that this contribution may aid in some small way to help establish a basis for a better understanding of the needs, usefulness, scope, and purpose of music therapy in the rehabilitation and treatment of the mentally deficient and physically limited.

II. DEFINITIONS OF TERMS USED

Music Therapy. The question, "What is music therapy?" is one that has been recurring ever since the existence of music therapy per se. Webster says that music is ". . . the science or art of pleasing, expressive, or intelligible combination of tones, rhythm, and dynamics. . . ." He explains therapy as ". . . of or pertaining to the healing art; concerned with remedies for diseases; curative. . . ." ¹

Tool, medium, modality. Within the past fifty years, more and more emphasis has been placed upon the basic principle which describes music as a tool, medium or modality used in therapy. Actually, in describing music therapy, we should possibly be more concerned with a description of therapy than with a description of music. In all the allied therapies used during the rehabilitative process, the basic factor, therapy, remains constant while the modality or medium with which the therapist approaches his ultimate goal is the variable. Occupational, industrial, recreational, or music therapists work with different modalities, though their goals or principles may be

¹Merriam W. Webster, Webster's New Collegiate Dictionary (Springfield: G & C Merriam Co., 1949), p. 720.

the same. (Analyzing the powers of music, one should keep in mind that music has always been an important factor in the emotional, cultural, intellectual, and spiritual life of people, and as such, has exercised therapeutic influence. Music, "the universal language" even more than the spoken word, lends itself as a therapeutic tool because it meets with little intellectual resistance and does not need to appeal to logic. It is a subtle and primitive driving force.²)

²Edward Podolsky (ed.), Music Therapy (New York: Philosophical Library, 1954), p. 26.

CHAPTER II

REVIEW OF THE LITERATURE

History of Music Therapy. Since the beginning of time, man has used music as a therapy in one form or another to cure the sick and aid the mentally afflicted. Although most people think that music in therapy is a relatively new field, it has been in existence for many centuries, both as a problem to be investigated and as a functional medium in controlling emotion. Man is basically animal and cannot remain aloof to music because tone and rhythm, of which music is composed, have a strong affinity for organisms and therefore man has become conditioned to sound and rhythm. Man is essentially a rhythmical being since there is rhythm evident in respiration, heart beat, speech, gait, and digestive functions.

Throughout recorded history, there have been references to the use of music in the treatment of the mentally ill, the mentally deficient, and the physically handicapped. The influence of music on personal behavior dates back to the pre-Christian era when the early Greeks and Romans, realizing the potentials of music, plucked their kitharas and lyres to drive away the evil spirits and comfort their ill.¹ Truly

¹"The Greeks and Musical Therapeutics," Etude, 63: 489, September 1945.

this play on human emotion is not a new one. Plato (427 B.C.) and Aristotle (384 B.C.) established, through experimentation, the fact that different genera (modes) conveyed different emotional aspects and curative powers. The ancient Greek philosophers were keenly conscious of the influence of music upon the emotional well-being of people. Asclepiades (124 B.C.) cured deafness with the sound of a trumpet (tubae), Xenocrates (396 B.C.) calmed maniacs with the sound of a lyre, and Atheneaus eased epilepsy with the music from his flute. Even in Biblical references, we find the following:

At that time it came to pass, when the evil spirit from God was upon Saul, that David took his harp and played with his hand, so Saul was refreshed and was well, and the evil spirit had departed from him. . . .²

The relationship between music and medicine among sub-cultural peoples also played a distinct part in the etiology of music therapy. Among these people, music was primarily used with dance or words. Unlike music composed today, music had little aesthetic or emotional meaning to primitives. Its value lay with the larger social objectives or goals. Instrumental music as such was practically unknown and the significance of the drum, rattle, flute, etc., in the treatment of diseases was not yet known. Among

²I Samuel 16:23

the primitive Indians, certain practitioners (shamen or witch doctors), were called upon for specialized healing because they had the power, inherent in their repertoire of songs, to heal certain types of wounds or illnesses. It was more the meaning of the words than the stimulus of the music that functioned in these cases. With the aboriginal peoples, it was obvious that the effect of music upon the sick man was that of heightening and intensifying his resolve to become well. The aboriginal man understood that illness was not merely a physical condition, but in many cases was an interplay of mental and physical ailments. The witch doctors had certain basic facts of which they were reasonably certain. Within the aboriginal tribe, infectious diseases were uncommon and the existence of true psychoses had never been noted. The vast majority of ailments seem to have been respiratory in nature. There were also skin infections and other illnesses brought about by insect bites or food poisons, and various bodily injuries due to everyday living. Therefore, by a process of simple elimination, the aboriginal "doctor" had a framework of reference within which to work. He was fully aware of the interpersonal relationships among tribesmen and went out of his way to discover who among the sick man's tribesmen was likely to cause him to become sick or fill his mind with uneasiness. These primitive people resented disease and sickness because

of its economic and social consequences. The relationship of the patient to the priest-practitioner is better understood in this light.

It is difficult to determine the extent to which music plays a distinct role in the treatment of disease within the primitive tribes. It is known, however, that songs often accompanied the administration of an herb or drug and that these songs exemplified the powers which the practitioner possessed. Many times these songs, as well as the musical instruments used, were considered useful in driving away illness and healing wounds. With the Ojibwa tribe, for example, the Jessaked practitioner functioned simply by sitting near the patient and singing songs to the accompaniment of his gourd rattles. With the priest-practitioner, however, where religion played a part in healing, music was integrated into the entire treatment program. He stressed the psycho-therapeutic point in the relationship between himself and the patient. { Music was employed only to help the patient obtain a maximum concentration of mind and body, thus intensifying his will to recover and attain physical well being. } In this case, unlike the situation where herbs alone were administered and in which the patient played a passive role, the patient played an active and conscious role.

Among the Mataco Tribe of Argentina, the belief was

that illness was caused by a disease spirit which had to be expelled. The cure consisted of a song without words. The singing was punctuated by the rattling of gourds, the clacking of necklaces, and the whistling of flutes. Each tone of the whistle seemed to indicate a new phase in the sequences of evidence and a new metamorphosis of the spirit of the medicine man.

With the Eskimo, the audience or tribe functions as a mere chorus in a patient-practitioner drama. In North-eastern Asia, the Siberian Shaman is well known for his use of a symbolic drum and here, the prominence of music is accepted. However, as with the Mataco Tribe, the drum and its music have no obvious connection with the cure of the patient. They are exclusively a symbol of the Shaman's power over the spirits. Music is merely the emblem of his profession.

For the American Indian, music plays an important role in healing, and the songs used in various treatments are said to come from supernatural sources (in dreams or visions); with this music come directions, procedures, and a knowledge of the herbs to be used. There are differences of custom between tribes and between individual witch doctors, but the prevailing characteristic of Indian healing songs is irregularity of accent. Interruption of a steady rhythmic pattern throughout the melody is typical.

Indians never sing with expression but with a monotonous, even tone. The rhythm is impressed upon the mind of the patient and the pattern holds his attention, bringing on a somewhat hypnotic effect. Healing songs are sung a definite number of times, usually three, four or five.

These examples will suffice to show the close relation between music and medicine among the Indians and the deep faith of these primitive peoples in the healing powers of music. The white man has developed his own methods of music therapy, but in isolated places, the Indian doctor still sings the songs that come to him in dreams while his patients listen and recover.³

People of old may not have understood music as we do today, but the basic principles were the same. The study of Greek culture reveals that they recognized the use of music in mental hygiene. One of the seven muses, Euterpe, was in charge of music. The therapeutic properties of music were keenly appreciated by the Greeks. Apollo, the God of the Sun, exercised a double function as God of Medicine and God of Music. The Greeks attributed the aesthetic qualities of music to three genera or modes, as they are now called; the DIATONIC or manly mode, used to march soldiers to battle; the CHROMATIC, or sweet mode, used to sooth the mentally ill; and the ENHARMONIC, or effeminate mode, used to complement reflective, thoughtful situations.⁴

³Dorothy M. Schullian and Max Schoen (ed.), Music and Medicine (New York: Henry Schuman, Inc., 1948), p. 45.

⁴"The Greeks and Musical Therapeutics," Etude, 63: 489, September 1945.

Regardless of the terminology used, music therapy has been utilized in some form or other as a curative medium for thousands of years. Today seems to be merely a reorganization of the past. Hippocrates (400 B.C.), the great physician, took his patients to the temple where he played music to them when he failed to cure them with medicines. The Arabs in the 13th century installed music rooms in their hospitals. Even in the 18th century, Pargeter, an English alienist, was doing research in music and therapy, and with the arrival of the experimentation method in the 18th and 19th centuries, a new orientation concerning the influence of music developed.

Interesting reports appeared in Europe and in our own country in which the effect of music upon metabolism, muscular energy, blood pressure, and pulse was described.⁵ An amazing impetus was given to the use of music in therapy by the military hospitals of our nation. (Clinical reports dealing with observations made on groups of mental patients also appeared, and in the ensuing years prominent people began a series of long-range experimentation in various areas of music and its therapeutic effects. With the aid of some major institutions, such as, Walter Reed General Hospital, Russell Sage Foundation, and the National Association

⁵Podolsky, op. cit., p. 29.

for Music Therapy, a social awareness to the use of music in therapy has been established.

After World War II, Walter Reed General Hospital spent millions of dollars in research, classifying music into specific categories such as stimulating, sedative, gay, soothing, or sad, and discovered definite patterns of behavior obtained by using certain types of music.⁶⁾

Since the time of primary classifications of music into specific categories, many studies and experiments have been performed by specialists and doctors in the field. A few of these are:

1. Tarcharnoff and Dutton did considerable work on music and its effect on metabolism.
2. Fere, Seashore, Tarcharnoff worked on increases and decreases in muscle energy and fatigue induced through music.
3. The Binnet and Courtier studies dealt with the particular effects of music on blood pressure.
4. Patrizzi accumulated data on music and its effect on cerebral circulation.
5. Hyde and Scalapino worked on the interesting line of increases and decreases of electrical energy produced by the heart.
6. Derbyshire studied music's effect on the body's Berger Rhythm.
7. Burdock, O'Niel, and Rusca checked extensively into pain increase or decrease in relation to the music played.

⁶Willem van de Wall, Music in Hospitals (New York: Russell Sage Foundation, 1946), p. 86.

8. Malisoff and Florsdorf found and recorded the particular chemical changes which took place in the body when certain types of music were played.
9. Binet, Weed, and Guilbaud studied the effects of music on breathing acceleration and irregularities.

These are a few examples of outstanding experiments, all studies done by specialists in their own field under controlled conditions.⁷

Its use and growth today. In hospitals, doctors and staff have found that therapeutic exercises are much easier for patients when suitable music is played. Music creates "authorized" patterns and gives the patient something to concentrate on other than himself and his particular illness or handicap. In fact, doctors have gone so far as to use music in the labor rooms of maternity wards, as well as in the "prep rooms" and operating rooms themselves.⁸ Dentists use music as a diversion and as an aid in lowering pulse and respiration rates during oral surgery. Music, with its great motivational factor, has been used in factories and prisons, churches and mortuaries, hospitals, nurseries, department stores and offices, and even in poultry and dairy

⁷"Music in Therapy," Education, November 1946, 46:158; see also Doris Soibelman, Therapeutic and Industrial Uses of Music (New York: Columbia University Press, 1948), p. 27.

⁸Ray Green, Hospital Music Newsletter (New York: Hospital Music Committee of National Music Council, 1951), Vol. III, #2, p. 2.

farms. The extended use of music today in various areas of concentration has proved without a doubt that more and more people are becoming aware of the vital importance of music in everyday living.

In the establishment of music as a functional medium in rehabilitation, it would seem appropriate at this time to name a few of the prominent individuals whose outstanding work paved the way toward the acceptance of music as a therapy. (Willem Van de Wall of Philadelphia and Ira M. Altschuler of Michigan are two of the first pioneers in America to establish music therapy on a professional basis, and develop some basic concepts which still are in effect.) Many others have played important roles in developing not only national recognition of music in therapy through the formulation of the National Association for Music Therapy, but also standards for educational and clinical training on the national level. They established a core group in behalf of music therapy. The primary group was called the National Music Council. The official publication of this primary group was entitled Hospital Music Newsletter, and volume one, number one, was published in May, 1948, under the chairmanship of Ray Green, New York. In January of 1951, Esther Goetz Gilliland of Chicago, Illinois, edited the first volume of the Bulletin of the National Association for Music Therapy. All of these publications since May, 1948,

have carried significant information concerning the present use of music in therapy, program planning, experiments being carried on in the field of music, college requirements for the music therapist, clinical experiences of workers in the field, and progress reports of the various committees functioning under the national association. On December 27, 1950, the National Association for Music Therapy held its first annual meeting in Washington, D.C., in conjunction with the 75th annual meeting of the Music Teachers National Association.⁹ A wide variety of subjects and problems in the field of music in medicine was discussed by distinguished speakers and experts in their fields. Meetings have been held annually and a yearly book of proceedings, published by the National Association for Music Therapy, contains a compilation of reports and materials presented. Eight books through 1958 are now available.

Music proved its worth as a therapeutic medium during World Wars I and II, and a need for trained musicians in this field of service was noted.¹⁰ In 1944, Dr. Roy Underwood, Chairman of the Music Department at Michigan State College, organized a four-year course of study leading to

⁹Ibid., p. 1.

¹⁰ Esther Goetz Gilliland, editor, Music Therapy 1951 (Chicago: National Association for Music Therapy), 1952, VII.

the Bachelor's Degree with major emphasis in music therapy. Due to the work of Doctor Ira M. Altschuler, well known psychiatrist and authority on music therapy, and the late Doctor T. K. Grueber, then superintendent of Wayne County Hospital at Eloise, Michigan, an internship program was inaugurated. In 1946, a training course was established at Chicago Musical College with internship at Downey Veterans Administration Hospital, under a training program devised by Doctor Jules H. Masserman of Northwestern University Medical School. The University of Kansas at Lawrence, Kansas, under the supervision of Dr. E. Thayer Gaston, offered a Master's Degree in Music Education with internship at Topeka State and Winters Veterans Administration Hospital, under the supervision of Doctor Karl Menninger. Alverno College of Music in Milwaukee, Wisconsin, College of the Pacific at Stockton, California, under the guidance of Mrs. Wilhelmina K. Harbert, New England Conservatory of Music, Boston, Massachusetts, to name but a few, are now offering courses leading to degrees with major emphasis and clinical experience in the field of music therapy. This has come about through the realization of a need for establishing educational standards and coordinating training courses. With the advent of greater demands upon the music therapist and with a greater demand for music therapists in general, colleges and universities throughout the country have been

striving to meet the need for qualified personnel. This necessitated an evaluation of therapy as a complex art, involving not only a knowledge of the patient as a total personality, in the method of treatment with music, but also a knowledge of many other extrinsic factors or variables. Therefore, a mere understanding of music is not enough. The functional use of music in institutions requires that one should have a knowledge of many allied fields, including anthropology, psychology, biology, physiology, philosophy, sociology, musicology and music education. In addition, the music therapist should have a well-integrated personality, proper attitude toward the patient, maturity, experience in group work, qualities of leadership, and emotional stability.¹¹ On the college level, and on the state level, the potential music therapist has many demanding standards to meet.

(In the last fifty years, significant strides have been made in the area concerning "influence of music on behavior," and many hospitals have given consideration to the use of music as an adjunctive therapy.) The training program mentioned above, which started in approximately 1944, was probably responsible for the greater development

¹¹Mariana Bing (ed.), Music Therapy 1953 (Lawrence, Kansas: National Association for Music Therapy, 1954), pp. 194-201.

and use of music in hospitals. (Music as an adjunctive therapy may possess therapeutic value even when it is used as a diversion or recreation. Its value lies in the contribution which it makes to the total push program.¹² Music is merely the tool with which the therapist works. It is a medium of expression and a bridge from therapist to patient. The extent, content, and practical value of music in the total rehabilitation program will be determined by the amount of professional interest and ability on the part of the hospital staff.)

Some basic principles. Let us consider two major classifications of music in therapy:

1. Active: The patient himself joins into group singing, instrumental groups, etc., simultaneously helping to break down the sense of isolation common to the physically handicapped and mentally retarded.
2. Passive: The patient merely listens or watches, allowing his mind and body to respond as naturally as possible, e.g., movies, stage shows, concerts, etc.¹³

Music can be administered in a great many ways and under many guises, and the patient should be allowed to share in as many different means of musical expression as possible. / The radio and phonograph are extensively used in

¹²"Music Therapy as a Career," National Association for Music Therapy [n.d.].

¹³Schullian and Schoen, op. cit., p. 334.

passive therapy, but rhythm bands, dance bands, vocal ensembles, instrumental ensembles, dancing (social and folk), group singing and creative interpretation are some media in active therapy. Group singing, which takes relatively little effort and preparation, affords immediate satisfaction and is an universal method in use. Small instrumental ensembles (or bands) are fine socializing influences and instigating devices of the "we" feeling and desire to "belong." It is an accomplishment of doing something together, and is a fine exercise for the mind in concentration and self-control.) Theatricals and minstrel shows are always well accepted and afford a means of self-projection through hero-roles or comedy roles. Private instruction in music or directing is quite helpful, both physically and psychologically. Since rhythmic body motions are a natural response to music (sensory motor), rhythmical exercises are set up to music as an integral part of the hospital's curative program.

Music is often used in the hospital as an adjunctive or adjuvant medium with occupational crafts, and recreation as well. However used, the therapist must be aware of certain responses which occur to various musical stimuli. A few of the more important reactions may be classified as follows:

1. SENSORY-MOTOR Response: One which occurs without

awareness and one which is due to sound stimuli or impulses which give way to rhythmic impulses in the muscles, e.g., tapping of feet, swaying of head, etc.

2. MENTAL (Perceptual) Response: One in which the person is aware of his bodily motion. Person may become sad, gay, angry, etc., in listening.
3. KINESTHETIC Response: One by which the listener, becoming aware of his desire for bodily response to musical stimuli, feels an impetus to express it in bodily motion and action.
4. ASSOCIATIONAL Response: A re-awakening or re-occurring of moods instilled at some previous time.¹⁴

By determining the type of response (or combination of responses) desired, it would appear that the music therapist would have a valuable tool with which to work.)

(Since the primary classification of music into specific mood categories, it has been recognized that behavior patterns can actually be modified through the use of music.¹⁵) All programs, however, for the deficient, the physically handicapped, and the mentally ill should be geared to the degree of deficiency, disability, or illness, as well as to other extrinsic factors involved, such as past experiences, personality conflicts, or facilities. The patient and his needs are of prime importance, music is but the tool.)

¹⁴van de Wall, op. cit., p. 86.

¹⁵Sidney Licht, Music in Medicine (Boston: New England Conservatory of Music, 1946,).

Some of the valuable uses of music as a functional experience may be summarized as follows:

1. Music provides for emotional release and balance through rhythmic activities.
2. Music offers personal satisfactions and feelings of success.
3. Music provides an orderly sequence of educational experiences through the use of simple instruments.
4. Music develops growth in social awareness through a wide variety of group experiences.
5. Music satisfies the desire for achievement through success in the mastery of a skill (no matter how simple.)
6. Music provides a means of changing behavior attitudes from negative to positive through happy, functional experiences.
7. Music expands horizons, enriches other areas of learning, and expands and lengthens the span of attention.¹⁶

These may be termed as basic, not only for the so-called "normal," but also for the deficient, the handicapped, the emotionally maladjusted, or the mentally ill. (The secret of the relative success of music in therapy is the degree of functional happy experiences through music, suited to basic physiological and psychological needs.)

The above-mentioned are gained through various

¹⁶Wilhelmina K. Harbert, "Some Principles, Problems, and Techniques in Music Therapy," (unpublished Master's thesis, College of the Pacific, Stockton, California, 1947).

methods in music. In the hospital situation today, we find mixed choruses, orchestras, bands, dance ensembles, rhythm bands, men's and women's glee clubs, directed listening programs, barbershop quartets, instrumental instructions on group and individual bases, general music appreciation choruses, calisthenics with music, talent shows, music with electro-convulsive-therapy, hydro-therapy, and physical-therapy, and singing games. These are but some of the methods used by the music therapist in an effort to create a functional experience for both active and passive patients. (The actual role of music therapy is but a small part in the therapeutic wheel which revolves around the patient. The occupational, industrial, recreational, and music therapists, chaplain, psychologist, social worker, psychiatric technicians, nurses, doctors, etc., are all "spokes" in the wheel of forces which stem from the most important area--the "hub" or patient. See appendix C.)

With regard to therapeutic music in allied areas, we shall concentrate on the use of music in the hospital situation. This can be broken down into three specific fields: (1) The State Mental Hospital; (2) the Veteran's Administration Hospital, and (3) The Hospital for the Mentally deficient and Physically handicapped. This chapter deals with music in a general sense. In the Veteran's Administration Hospitals, the music therapist is generally termed

a recreation leader in music, and works in the division of special services. In the May, 1948, edition of the Hospital Music Newsletter, we find an interesting report on Veteran's Administration Hospital music. Music activities are broken down into two major divisions, recreational and music prescribed by the medical staff. Under recreational, we find music activities which include band and orchestra, glee club and choir, request programs, hill billy bands, rhythm bands, etc.; also under recreational we find music entertainment which includes community and ward sings, concerts and recitals, selected radio concerts, and music quiz programs; a third division under recreational, would be music instruction, which would include individual and group sessions on the vocal, instrumental, and creative levels, live music recitals with comments from patients, and music appreciation groups. Under the division of music activities requested by medical personnel, we find specialized activities, which would include such programs as music in hydro-therapy, electro-convulsive-therapy, pack rooms, insulin shock, and in the disturbed dining hall situation. In addition to specialized activities, music activities under recreation, entertainment, and music instruction are available to the medical staff upon request. This shows graphically how the general music program is planned and operated in the

Veteran's Administration Hospital.¹⁷ It indicates basically a two way approach to the use of music in therapy: (1) music as a recreation, and (2) music activities requested by medical authorities. Though this program has changed slightly in the last ten years, it is basically the same in organization.¹⁸

In reviewing some of the various programs in a number of Veteran's Administration Hospitals throughout the country, it was found that music is used extensively in sports activities, patient participation in community programs, canteens, pageants, light operas, the dining hall, group recreation, hospital broadcasts, musical quiz shows, charades, rhythm bands and the like.¹⁹

Every sick person has certain feelings about his illness or hospitalization, whether he be in a Veteran's Administration Hospital, a hospital for the mentally ill, or a hospital for the mentally deficient and physically handicapped. The patient's mood is considerably affected by

¹⁷ Doctor Herbert Rubin, Use of Music in General Medical and Surgical Hospitals, Part III (Washington: Veteran's Administration, 1952), 136-225.

¹⁸ Additional information on the Veteran's Administration Hospital music program may be obtained by writing to the Chief of Music, Recreation Service, Special Services, Veteran's Administration, Washington 25, D.C.

¹⁹ Office of the Assistant Administrator for Special Services, Special Services Information Bulletin, Part I, IB-6-227 (Washington: Veteran's Administration, 1952), pp. 21-25.

fear, anxiety, self-pity, boredom, loneliness, and disturbing sights and sounds.²⁰ Since music appears to have an effect upon mood, it is extensively used in hospitals to influence patient's moods (Altschuler's iso-principle). Familiar music is also meaningful and there is really no "good" or "bad" music since this is determined by the patient's tastes, interests, and background. Taste in music varies with age, training, nationality, home-background, and other intrinsic factors, such as personality, religion, and thinking habits, and therefore, a large variety of programs in many areas is advisable.

(In the mental hospital,) music is used in much the same way as in the Veteran's Administration Hospitals. (Music is used extensively to produce or modify moods,) while in the hospitals for the mentally deficient where the mental capacity is at a lower level, music with marked rhythms is generally more effective and the prime purpose seems to be to activate the patient and create an interest. Marked rhythm arouses the feeling of excitement and happiness and most patients, regardless of their intellectual capacity, respond to basic rhythm. Live music is more useful than recorded music because of the influence of interpersonal relationships. (Community singing is valuable for maximum

²⁰Rubin, op. cit., p. 3.

group response.)

The psychological effects of sound may be manifested physiologically or intellectually, or in a manner which combines the two. Certain musical selections may gain no overt response, while others may elicit a chain of observable responses. Reaction to music in general is related to the psychological levels, sensations, perceptions, and imagination. These sensations are possessed by all and require a minimum amount of mental effort. Intrinsic effects are within easy reach of the intellectually superior and inferior alike.²¹

In orthopedics, music can be used as a form of occupational therapy. Playing the piano can be used to limber up joints and muscles, to loosen contractures and to develop strength and coordination of the hands and fingers. This technique can be used to help develop better flexion and extension of muscles. Arpeggios are good for exercises of the thumb. For active and passive finger exercises, scales on the black keys of the piano are excellent. The ukulele, banjo or guitar offer a means of exercising fingers in extension. An organ pump or piano pedal offers good exercise for the ankle and foot. The bass drum in a dance trap-set is also used for ankle and foot exercises.

²¹Ibid., p. 4.

Percussion instruments (in general) offer good exercise for wrist, shoulder, and elbow joints. The harp offers good exercise for the finger and hand muscles. Various types of vocal music aid in improving speech impediments and developing diaphragm control. Wind and brass instruments are excellent in the treatment of lung deficiencies. With proper guidance and supervision these wind instruments are extremely valuable in the therapeutic treatment of the cerebral palsied child and physically handicapped.²²

In our hospital setup today, music is also used (extensively) with the tubercular and post-polio, as well as with the emotionally maladjusted and mentally-disturbed patient. Dance music is a means of relaxation. It tends to promote a sense of "belonging," facilitates group participation, and aids in socialization. This can also be said for folk and square dancing, as well as small group ensembles and rhythm bands. General hospital parties and performances might include musical action songs, dramatized stories and songs, musical skits, minstrel shows, music quizzes, and similar activities. Most patients are interested in participating in such activities and the music therapist often uses this interest as a tool in

²²William M. Cruickshank, and George M. Raus (ed.), Cerebral Palsey (Syracuse: The Syracuse University Press, 1955).

developing the overall program. The non-ambulatory patient can gain satisfaction in special ward programs, with the use of the radio, television, and record player in diversional activities designed to meet his particular limitations. Bed patients of long-termed hospitalization look forward to professional entertainment of all types. Consequently the volunteer program may be used to the fullest extent. The success or failure of this type of ward activity will be determined by the proper choice of instrumentalists and music. For instance, vocalists with high range voices, such as lyric sopranos, are not generally good choices, while quartets are usually most acceptable. Formal and informal music appreciation and listening programs are often conducted on the wards and it is possible to place record players in day rooms and sun porches. Many patients will bring their own records.

(In the educational area of music in therapy, individual and group instruction on instruments or voice often help patients in deciding whether or not they would like to continue music after hospitalization, either as a hobby or as a serious study. In the hospital for the mentally deficient, this may be a long-range program and a slow process, but the end results, nevertheless, may be just as effective. In the hospital for the mentally ill or the Veteran's Administration Hospital, special music courses in fundamentals of music,

theory of music, keyboard harmony, instrumentation and arranging, and composition, open an avenue of creativity and an opportunity for more thorough individual work. The therapeutic value will vary according to the patient's interests, abilities, and limitations. Meal-time music controlled by the music therapist is most desirable not only for the mentally ill and emotionally disturbed, but for the mentally deficient as well. It creates a quiet permissive atmosphere and aids in controlling the patients. After-dinner music benefits digestion and metabolism.²³

In the hospital surgical program, music is sometimes effective with surgery or dentistry. While a patient is under spinal, local, or regional anesthesia, music can be a vital tool in modifying the mood of the patient or as a mere diversion.²⁴ Specially selected rhythmic music can be used with corrective exercises. In the sports department, recorded music can be used during games. As an adjunctive therapy, music is used as a background for creative art experiences, finger painting, clay modeling, and weaving in occupational therapy. Trips to concerts and musical events outside the hospital can be scheduled. These create much

²³Max Shoen, The Effects of Music (New York: Harcourt, Brace & Co., Inc., 1927).

²⁴Doris Soibelman, Therapeutic and Industrial Uses of Music (New York: Columbia University Press, 1948), pp.160-172.

interest and can be valuable for discussion purposes before and after the trip. Musical entertainment in auditoriums or large recreation halls might consist of variety shows, dance bands, military bands, vaudeville acts, singers, dancers, movie stars, radio broadcasts, and celebrities of the music and entertainment world, as well as large recreation activities, such as dances and birthday parties.

Both patients and visitors appreciate music in the visiting rooms and bed-time music can be of great value if properly selected. Church music might include Catholic, Protestant, or Jewish choirs, patient-employee choirs, glee clubs, orchestras, or individual instrumentalists or vocalists. Most music programs may be implemented by the use of trained volunteers who make it possible to keep music programs available to patients many extra hours, including Sundays and holidays. This is also a valuable way of expanding the music program to reach many of the wards which the music therapist might not otherwise have time to cover.

These are but a few of the ways in which music in therapy is being used in the mental hospital, the Veteran's Administration Hospital, and the hospital for the mentally deficient and physically handicapped. The extent and scope of the development of these programs on a statewide and national basis depend entirely upon the desire and interest on the part of the medical staff to develop a program in

accordance with the patients' needs and desires for such activities.

A look to the future. A look to the future and the progress of music in therapy may best be done by reviewing some of the current research developments within the past five or six years. This will enable us to determine the value of music as a therapeutic tool.

Certainly the extent of research done by prominent people in the fields of music, psychology, medicine, and education would be an indice to the "forward push" in this field. The National Association for Music Therapy organized a music therapy research committee consisting of A. Flagler Fultz, chairman; Ira M. Altschuler, M.D., E. Thayer Gaston, Ph.D., and Jules H. Masserman, M.D., for the sole purpose of instigating, encouraging, structuring, and reviewing research in the field of music therapy. Their scope and function can be explained as follows:

1. To identify and state critical hypothesis in need of being tested and explored.
2. To clarify and help define basic concepts in music therapy.
3. To aid the Executive Committee in publicizing information on experiments, findings, conclusions, and research projects for further verification and replication.
4. To serve as a clearing house to help avoid futile or ill-advised research pursuits, by suggesting

improvements or changes in experimental design in the interest of more efficient investment of time and resources.

5. To provide some model experimental designs that might be at once general and typically suitable for investigating by standard approaches several sample problems.
6. To accumulate a "suggestion barrel" out of which to recommend good, well-formulated problems that may fit into a larger scheme of music therapy, having in mind a broad twenty-year plan of study.
7. To enlist the cooperation of clinical centers, music schools, and graduate schools, such as have departments of psychology, music education, medical schools, etc., whose students or research personnel are capable of pursuing the study of crucial problems in this field.
8. To develop an evaluated listing of a music therapy bibliography which may be made available to persons needing such materials.
9. To aid in the liaison between the National Association for Music Therapy and the various psychiatric and medical associations.²⁵

The first collection of abstracts of research projects appears in the 1951 edition of the National Association for Music Therapy, Book of Proceedings.²⁶ Some of the more interesting surveys dealt with:

1. A study of the sedative effects of music for acutely disturbed patients in a mental hospital, by Donald E. Michel. This was primarily a study of the sedative effects of music for acutely disturbed patients in a typical ward situation at Winter Veteran's Administration Hospital, Topeka,

²⁵Gilliland, op. cit., pp. V and 179.

²⁶Ibid., pp. 182-201.

Kansas. A secondary problem was to observe the general effects of regular, planned, recorded music programs upon locked ward patients. Clinical observation was the general method applied in this study. An attempt was made to control as many of the affective factors as possible so that a reasonably valid observation of the effects of music might be made.

2. The effects of music in insulin coma therapy by Robert Unkerfer, Assistant Director of Adjunctive Therapy, Meninger Foundation. This study deals with the application of atmosphere music in a particular type of treatment in the modern highly organized mental hospital. The basic problem in the study project was that of super-imposing a program of recorded music on an already existing insulin coma treatment routine.
3. A study of the spontaneous rhythmical activities of pre-school children by Geneva Scheihing, Adjunctive Therapist, Meninger Foundation. The purpose of this study was to find as exactly as possible what natural rhythms are expressed by pre-school children in their free vocalizations and their free-motor activities.
4. The influence of music on the selections of pictures by Olga Pytlar, Music Therapist Intern, Winter Veteran's Administration Hospital, Topeka, Kansas. This study was to determine basically three things: (1) Are there common meanings derived from music? (2) Does the meaning of music for the ill differ significantly from that for the normal? (3) Are personality structures or diseases entities indicated by significantly different meanings? These questions were to be answered by having patients and non-patients select pictures which best fit the music to which they listen.

Other investigations now in progress are:

1. Beavers: an attempt to determine the relationship of successful rhythmic participation and social adjustment in school children by means of a series of specially designed rhythmic response tests correlated with reports from various sources as to each subject's social adjustment.

2. Hardy: using 1000 children, grade school through high school, for obtaining prose, poetry, or pictorial responses to music, the type of response being suited to the subject's grade level.
3. Music staff of Winter Veteran's Administration Hospital conducting music sessions on a ward of regressed patients in an attempt to determine the effects of music for motivational and sedative influence in the routine of the ward, so that appropriate music can be played on the ward to suit the activity going on at a given time or as needed for some special occurrence or disturbance.
4. Marcus Hahn: an extensive study of 12 subjects, correlating each subject's personality characteristics with his musical preferences.
5. Irwin Schneider: a project to investigate the application and effects of music with speech handicapped children.
6. William Sears: a study of the relationship of tonal auditory stimuli to neuro-muscular tension.
7. Dr. James F. Nickerson: studying the difference in response to stereophonic and to conventionally produced music.

It would take a complete book to list all of the research projects concerning music in therapy. The above mentioned are but a few such studies listed in the first National Association for Music Therapy, Book of Proceedings. In each of the six successive books through 1958, there appear abstracts of more recent and more intensive research projects. The significant factor, however, seems to lie in the fact that more and more people are becoming aware of the need for well-controlled and highly specific, technical research on a professional level. Hospitals and educational

institutions throughout the country are encouraging their students and staff to participate in the research program under the auspices of the National Association for Music Therapy. (A look to the future certainly indicates the trend outlined in the purposes and objectives of the National Association for Music Therapy:)

The progressive development of the use of music in medicine, through:

1. advancement of research
2. distribution of helpful information
3. establishment of qualifications and standards of training for therapists
4. perfection of techniques of music programming which aid medical treatment most effectively.²⁷

In the total push program toward the recognition and acceptance of music in therapy, both nationally and internationally, Phi Mu Alpha Sinfonia Fraternity of America, national honorary professional music fraternity, has formed a Sinfonia foundation in an endeavor to promote music therapy. In the Phi Mu Alpha newsletter, Mr. Bob Schmitt, President of the new Sinfonia Foundation, outlines in specific detail the apparent need for such sponsoring groups and the inherent details of the Foundation as it stands today.²⁸

²⁷E. Thayer Gaston (ed.), Music Therapy 1956 (Lawrence, Kansas: National Association for Music Therapy, 1957), p. VII.

²⁸Phi Mu Alpha Newsletter, Vol. VII, No. 6, April, 1958.

In 1957, a questionnaire was sent to all members and alumni of the fraternity. This questionnaire dealt with the future plans and endeavors of the Sinfonia Foundation to be established. In February of that year, Mr. Schmitt spearheaded a series of discussions between the executive committee of the fraternity and the Administration Committee of the National Association for Music Therapy. Representing the National Association for Music Therapy were Mrs. Dorothy Brin Crocker, President; Dr. Roy Underwood and Doctor E. Thayer Gaston, Past-presidents. Plans were made at this meeting for a fund-raising and solicitation campaign on the part of the Foundation to give the National Association for Music Therapy the financial backing it needed for a far-reaching four-step research project in the science of functional music. The research, which will receive the financial backing of the Sinfonia Foundation, will be concerned with the "science" of music, the why and how and when and where of music. There has been some scientific investigation into psychological responses and concomitant emotional reactions to music, a little in participation activities, more in the area of listening. Further basic research and reliable reporting on projects is needed to establish and test hypotheses, but such investigation is a slow, expensive, and painstaking process. The Sinfonia Foundation, interested in the field of research in music therapy, will provide

financial aid to the National Association for Music Therapy in the form of scholarships to qualified students in the field, financial aid for student internship programs, and monetary backing for detailed research projects.

It is with great anticipation that we look to the Sinfonia Foundation as a springboard in the organization of many more such foundations throughout the nation in an effort to further establish the validity of music in therapy, to better understand the meaning of and use of music in therapy, and to enable more progress through research.²⁹

²⁹Frank W. Hill (ed.), "Sinfonia Foundation Reports," Phi Mu Alpha Sinfonia Newsletter, Vol. VII, No. 6, 1958.

CHAPTER III

SONOMA STATE HOSPITAL AND THE REHABILITATION PROGRAM

Hospital and patients. "Sonoma State Hospital is one of the facilities of the California Department of Mental Hygiene established for the care, treatment, and training of part of the state's mentally retarded."¹ This institution houses approximately 3300 patients, many of them physically handicapped, and many of them emotionally mal-adjusted as well as being mentally deficient. Also an institution of this type houses the epileptic, the cerebral palsied, the psychotic, the post-polio, the tuberculin, and the patient with neurological and congenital disorders. As in most institutions of this type, the patients' ages range from infancy to well over eighty years.

The thirty-two ward units and three hospitals house the 3,252 patients at Sonoma State Hospital. A representative and statistical description of some of these wards is as follows:

GROMWELL: Rated capacity - 80 Ward population 100
Semi-ambulatory, age 2 to 5 years. Young children just learning to walk and to feed themselves and some bed patients who require constant care. All children receive continuous treatment. Special

¹Personnel Department, Sonoma State Hospital, The Sonoma Story, revised 3/1500/8.7

education in food habits and toilet training is attempted as soon as the children are able to learn. All children eat on the ward.

DUNBAR:

Rated capacity - 69 Ward population 95
Younger boys of higher intelligence level, moron and higher imbecile. Pre-school who become emotionally excited and some pediatric illness on this ward. Patients eat on the ward.

BANE:

Rated capacity - 49 Ward population 62
Ward for pre-adolescent boys; behavior disorders; moron and imbecile level; ages 10 to 15 years; psychiatric observations for this age group; must have close supervision in recreational activities and preparation for school. Patients eat in the main dining room.

GODDARD:

Rated capacity - 67 Ward population 72
Higher intelligence, adolescent boys with emotional problems; some a combination of mental deficiency and psychosis; behavior disorders and psychiatric observation cases. This is a total push ward where group and individual psycho-therapy is in progress. Careful scheduling of activities is required from nursing personnel. Ages 10 to 17. Patients eat on the ward.

WRIGHT:

Rated capacity - 68 Ward population 93
Adolescent boys, ages 13 to 18 years; many are emotionally disturbed and require supervision and guidance; some attend school and some have detail training assignments. Patients eat on the ward.

THOMPSON:

Rated capacity - 126 Ward population 171
Boys over 18 years, ambulatory, high imbecile and moron; detail training group for kitchen, commissary, and mechanical departments. Not disturbed or security risks. Supervision, scheduling of activities and guidance required of nursing personnel. Patients eat on the ward.

MC DOUGALL: Rated capacity - 88 Ward population 82
Adolescent and young women of higher intelligence level, high imbecile and moron; ages 14 to 25 years; many have serious emotional problems. Some are security risks; close supervision is required. Includes observation and psychiatric cases. Patients eat on the ward.

OAK LODGE: Rated capacity - 52 Ward population 60
Adolescent girls and young women of higher intelligence level, many in school and on vocational training activities. Most all have a "work assignment." This is a "finishing" ward prior to placement outside of the hospital. There is no dining room on the ward, the patients eat at McDougall Cottage and are supervised by nursing personnel.

HILL: Rated capacity - 66 Ward population 100
Geriatric and crippled women and cerebral palsied and crippled girls. Some are chronic medical problems and require continued treatment. Habit training is a problem with the crippled. All patients eat on the ward and some must be fed. Ages from 16 to 60 years.

KING: Rated capacity - 86 Ward population 118
Geriatric and crippled men and some cerebral palsied younger men, ages 20 to 80 years. Some are chronic medical problems and require continued treatment. A nursing care problem on this ward is weight of patients in wheel chairs - lifting for bathing, toileting, and in and out of bed. All patients eat on the ward.

STONEMAN: Rated capacity - 94 Ward population 110
Pre-adolescent and adolescent girls who are ambulatory but present many behavior problems and are of lower intelligence level. They must have special attention in toilet training, eating, and play activities; require close supervision at

all times. Ages 7 to 14 years. All patients eat in ward dining room, require constant attention during these times.

OSBORNE: Rated capacity - 95 Ward population 130 Women, ages 16 to 60 years, of mixed intelligence levels. Approximately half of ward population assigned to work detail, the others stay on the ward, most are unable to do simple tasks. Habit training is necessary in some instances. Food is served family style in ward dining room. Training is attempted in table manners.

HAVEN: Rated capacity - 55 Ward population 74 Moderately and severely retarded women who require habit training and continuous treatment care. Must be closely supervised at all times and require extra attention at meal times; some must be fed. Ages from 20 to 50 years.

POPPE: Rated capacity 85 Ward population 110 Pre-ambulatory to early ambulatory and many bed patients ages 5 to 15 years, who require continuous treatment and nursing care. Some need special attention at feeding times, and about three-fourths of the ward must be hand fed. All patients must be lifted, bathed, and diapered by technicians.

FINNERTY: Rated capacity - 56 Ward population 62 A cerebral palsy treatment ward. Age not pertinent but essentially over five and under 21 years, I.Q. above 40 or by recommendation. Treatment for these children is provided in many ways: a physio-therapist, a special school teacher, and representatives from most departments of rehabilitation, especially in music and activities. All patients are fed on the ward.

Sonoma State Hospital provides care and treatment for mentally retarded patients and serves the northern counties

of the state. The level of care and the treatment techniques utilized at this hospital are comparable to those employed at other state hospitals for the mentally retarded operated by the department and emphasize treatment rather than custody.²

The over-all program is concerned with providing the very best treatment and care for any and all patients admitted. An effort is made to rehabilitate in as short a time as possible a maximum number of these patients, that they may be returned to the community as productive, adjusted citizens. Before a patient is admitted or accepted, a pre-admission clinic staff carefully reviews the proposed patient's case history to determine not only the nature of the illness or handicap, but also to determine whether or not the specialized treatment offered at this institution can benefit this particular patient. During the patient's stay at the hospital, the energies of the entire hospital staff are utilized in conjunction with the gamut of therapies and medicinal remedies to bring about rehabilitation of the patient. A basic three-part treatment program is followed:

- (1) Medical and psychiatric treatment and nursing care

²T. A. Bravos, Assistant Superintendent, Information for 1959-60 Budget Preparation, Sonoma State Hospital, Inter-office Memorandum - 1958.

- (2) Education and training
- (3) Rehabilitation and readjustment to the community

Each specialized ward or unit is directed by a physician-in-charge and all other personnel involved combine with this director to form a team to supply the needs of each patient. On a broader level, the doctors and psychiatrists, nursing service personnel, school department, and rehabilitation therapists work as an organized unit in a team approach. (See appendix C.)

Since the majority of patients at an institution such as this are children, the educational program involves not only curricular activities generally associated with a school department, but also the simple menial training skills such as learning to sit up, learning to walk, learning to talk, learning to feed oneself, toilet training, personal hygiene. Some of the older children who have learned to care for themselves, must now in their educational experience learn to care for others. In reviewing the patient's case history and relative improvements, the ward team may function to recommend certain patients for industrial placement either on the hospital grounds or in the community. In many instances, these work-training experiences have served as the basis for a patient's livelihood once he has left the hospital.

Sonoma State Hospital, as an institution, is not unlike a small city. The typical modern single-story,

100-bed cottages, make up the stereotype picture of this hospital setting. Each unit is built to house a typical type patient (with ramp entrances for wheelchair wards, screened windows for disturbed wards, for example), and is designed to meet the special physical needs of the population. A 110-bed acute medical and surgical hospital, a 180-bed tuberculosis unit, and a 120-crib nursery add to the facilities. In 1949, an appropriation of \$12,000,000 commenced an intensive building program. A 100-bed receiving hospital has recently been completed and a new two-story Administration Building is now under construction. Also under construction at the present time are two pediatric units (toddlers' units, one and two), plus two infirm and crippled units (one male and one female). These will bring the hospital capacity to 4100 by 1960. A new Rehabilitation Services Center and Chapel are being planned, with improvements and modernization of many of the existing ward units. A Psychiatric Unit, Research Unit, In-Service Training Center, and ten other ward buildings are in the offing. An addition to the school department, which now services 350 patients in an educational program, will further intensify the hospital's over-all training area. Other clinical services in the hospital include dentistry, chiropody, electro-cardiography, pharmacy, x-ray, physical therapy, electroencephalography, and other clinical

laboratory departments. Other facilities include a new \$1,500,000 kitchen, commissary, a modern laundry, maintenance shops, power plant, hog ranch, dairy, poultry ranch, orchards, water reservoirs and purifying plants, fire station, police department, and post office. This is truly a city in itself.

More than 1615 employees constitute the staff of the hospital. The medical staff consists of twenty-five physicians, fifty-seven registered nurses and specialists in such fields as psychiatry, pediatrics, pathology, surgery, etc. Of the 1615 employees, there are eight hundred and fifty psychiatric technicians, twelve psychologists, fourteen social service workers, seventeen rehabilitation therapists, twenty-four specialized school teachers, and three chaplains. Working together as a team are included three dentists, a chiropodist, two physical therapists, seven laboratory technicians, two x-ray technicians, and an electroencephalogram technician. Supplementing the above professional staff, are maintenance and tradesmen, fire and security forces, food service, farming, accounting, and clerical personnel. To augment specialized training, a 300-hour training program is required for all new psychiatric technicians. In addition to this, an in-service training program is also arranged for other personnel.

There are still many questions which remain unanswered

concerning mental retardation, its causes, and its treatment. Sonoma State Hospital is one of several institutions within the state carrying on intensive research projects concerning the causes, diagnosis, and treatment of mental retardation in a combined effort to discover and adapt new and better methods of care and treatment.

This, in essence, is the combination of personnel, tools, and media that help provide ". . . prompt modern treatment. . . to bring about. . . the fullest development of the mental and physical capabilities of the hospital patients and speed their return to their communities. . ."3

The total rehabilitation program. Rehabilitation is basically any purposeful activity that modifies or changes behavior of the patient involved and is, therefore, a treatment of the patient through activity. It is a program of activity that will meet the patients' needs, and one which will be meaningful. It should be controlled by the ward team through the establishment of goals and periodic evaluations.

The Rehabilitation Services Department serves as a functional discipline that is dedicated to the responsibility of utilizing all modalities available in an effort to produce a program through which each child or adult shall be

³Personnel Department, Sonoma State Hospital, op.cit.

developed to a maximum psychological maturation consistent with that person's potential. These goals are met through the Rehabilitation Therapist who is an expert in the interpersonal relationships developed through the activity or modality of the structure program. The therapist contributes, in direct work with the patient individually or in a group situation, or as a consultant or resource person to the other disciplines that will ultimately help develop the personality of the patient. The program, as it applies to each individual patient, is planned, organized, and implemented, as well as critically evaluated, by the therapists who are members of the Therapeutic Team. This Therapeutic Team, commonly known as the Ward Team, will make written and verbal recommendations on program and progress, and should be responsible for evaluating the program and recommending immediate changes. This program, however, shall be a combined effort to maintain through activity that which is normal in the patient, and to provide meaningful experiences that will contribute to personality development and help the patient adjust to any new experiences that will aid in his progress as an individual.

The Department is responsible for scheduling and operating the following Rehabilitation facilities: (1) The activity center with office space for one music therapist, one occupational therapist, one recreation therapist, two

industrial therapists, and two group leaders. This building includes a main recreation area with tables, chairs, a small kitchen, popcorn machine, sink, stove, and storage area, public address system, hi-fidelity sound system, and supplies. The recreation area has space for a badminton court, ping pong tables, two pianos, and a small platform. It seats approximately 150 persons at the tables. In this Activity Center is also located the Occupational Therapy Clinic areas, including a kiln, simple power tools, looms, a sewing room, wood-working shop, and a ceramics shop. The patients' library, also located in this building, includes the books, magazines, tables, and chairs, and office space for a Librarian. Rest room facilities are provided in this building for patients and employees. A beauty shop is part of the facility, but is not under the supervision of the Rehabilitation Department. (2) Eldridge Field. This outdoor recreation area includes a lighted softball field and a concrete tennis and basketball court. (3) Haven Cottage, (second floor). This area contains offices for one music therapist and one occupational therapist, an instrument repair workshop, a supply room, general work area, and rest room facilities. (4) School facilities are utilized by the Department, when needed, with proper clearance.

The over-all philosophy of the Rehabilitation Services Department is to involve all people who contribute to

patient activity. The important factor in noting progress is the detailed clinical analysis and evaluation of each therapist's program. Daily attendance is kept on each group by the individual therapist and clinical notes involving significant responses and reactions of patients are noted in writing after each activity. On a monthly basis, each therapist submits to his immediate supervisor, a report containing both statistical and narrative information. His immediate supervisor, in turn, combines the statistical and narrative material of all the therapists' programs into a cumulative monthly report which is then submitted to the supervisor. In this manner, it is possible for the Department to keep up-to-date clinical records regarding the progress of each patient and group. A monthly activity schedule (reh/20) is made out at the monthly planning meeting and lists on a daily basis each of the activities, place of activity, wards involved, and therapists in charge. Copies are sent to each ward, Nursing Service supervisors, telephone operator, administrative heads, and the Chief Rehabilitation Services in Sacramento.

I. MAJOR DIVISIONS OF THE REHABILITATION DEPARTMENT

The Rehabilitation Services Department consists of three major divisions: Ward Services, Centralized Services, and the Industrial Services. The Ward Services section of

Rehabilitation Services, through an Assistant Supervisor of Rehabilitation Services and under the direct supervision of a Supervisor of Rehabilitation Services, plans and conducts a rehabilitation program for patient units, wards, or groups referred for treatment by ward physicians or psychiatrists. Ideally, the program of the section is planned, organized, and implemented as well as critically evaluated, by the members of the Therapeutic Team, of which the Rehabilitation Therapist is one participating member. The team members include the physician or psychiatrist, who is charged ultimately with the responsibility of achieving the program objectives, and personnel of nursing services, social service, psychology department, the school department, and rehabilitation services. The program represents the sum total of the contributions of all the team members. Each therapist contributes (1) as a consultant to other disciplines in a program for the development of interpersonal relationships, in such a way as to result in the maximum personal satisfaction to the employee and the ultimate personality progress of the patient or (2) by direct work with the patient, either singly or in a group.

There are two levels of performance in the Ward Services Section, that of the Assistant Supervisor of Rehabilitation Services, and that of the Rehabilitation Therapist (with appropriate titles according to skills and

speciality).

The responsibilities of the Ward Services Section include direction of all activities (which are of a general activity nature) relating to Rehabilitation Services carried on in the patient units of the hospital. Within this framework, the Ward Services Section will give consultation service to the staffs of all patient units of the hospital, provide supplies for all Rehabilitation Services activities provided in the patient units in the hospital, supervise all volunteer activities carried on in the patient units in the hospital, and render other services as directed or requested. When staffing patterns permit, each member of the Ward Services staff is responsible for all rehabilitation services activities in a particular area of nursing services. Each member of the staff participates in the training of volunteer workers who come to the hospital to offer services and supports and directs the individual volunteer workers assigned to the area for which he is responsible. He also assists with and co-ordinates the activities of volunteer groups who provide programs within his area, and prepares clinical notes and evaluations on the activity.

The Ward Services Section also provides in-service training for members of the Nursing Services and Rehabilitation Services staffs and members of other departments of

the hospital as necessary. The instruction includes lectures and materials covering the definition of individual therapies, history of the discipline, description of Ward Services program operations within the hospital, and demonstration of particular patient activities. Each therapist is available to anyone of the staff or any unit within his area for the purpose of consulting and advising regarding program activities which may be carried on by the nursing service personnel or volunteers. The therapist may assist by providing demonstration programs, including activities which the nursing service personnel in the area may supervise, by teaching techniques and skills within the limitations of the patients and personnel in the area, and by providing guidance for development of education programs within the units. Where shortages of nursing service personnel are so acute that providing program activities on a unit would result in lowered standards of treatment of the patient, it may be necessary to inaugurate therapist-led activities on the unit. This is considered only as a temporary measure, however, always bearing in mind that the program may be taken over by the ward staff or volunteers at any time that conditions make it possible.

The members of the Ward Services Section attend Ward Team conferences as assigned by the Assistant Supervisor and approved by the Supervisor. In specific instances where

particular patients of special interest to any individual therapist are to be discussed, he may request permission to attend if arrangements can be made which do not interfere with regular programs, and if approved by the Assistant Supervisor or Supervisor. Any therapist may be called upon to attend various other meetings or conferences as deemed necessary.

Each month, the charge technician of each of the patient units submits to the Ward Services Therapist in charge of that particular area, a standard form showing activities carried on by ward personnel. The information contained in these forms will be reflected in the statistical report of the therapist, as outlined previously.

As a general rule, therapists conduct business and inter-personal dealings with members of other departments within the hospital in the normal progress of the affairs of the section. These relationships may be directly with other members of the staff whose positions are equal to or below those of the therapists in the scheme of hospital organization. As it becomes necessary for the therapist to conduct business, to consult, or to confer with staff members outside this general frame of reference, or in the event of unresolvable conflict between a member of rehabilitation and a member of any other department, the contact is made through his immediate supervisor.

The other major division of Rehabilitation Services is the Centralized Services Section. The members of this section, under the direct supervision of an Assistant Supervisor of Rehabilitation Services, who is in turn directly responsible to the Supervisor of Rehabilitation Services, function as a team to provide (1) specific intensive treatment for patients referred by the ward teams, (2) mass group activities on a large scale, (3) in-service training in the area of orientation and education, (4) volunteer supervision as assigned, and (5) assistance in other areas where the demand arises. The Centralized Services Section provides both individual and group referred-treatment programs and activities in all areas of rehabilitation through the uses of the various media and modalities, such as music, occupational and recreation therapies. Treatment sessions are held in the central clinic area or on the ward unit, as may be indicated by the age, physical condition, or needs of the patient. The program and activities are designed to meet the following objectives:

- (1) Emotional Release: To provide outlets for aggression and hostilities.
- (2) Socialization and Social Awareness: To establish a feeling that living with others is a less-menacing and less-fordoming experience; to create "we" feelings and a desire to "belong."
- (3) Self-awareness: Introspection, development of

tolerance and respect for individual needs and difference.

- (4) Change in Attitude and Behavior from Negative to Positive: Create an awareness that new patterns can be learned.
- (5) Expand horizons, enrich areas of learning and facilitate normal interest and relationships.
- (6) Develop a continuing interest in a hobby or a vocation which can be used as a functional tool after discharge.
- (7) Aid in developing skills and potentials.
- (8) Support and contribute to the efforts of the total hospital staff in carrying out therapeutic objectives.

The Centralized Services Section of Rehabilitation Services works with all patients, either individually or in groups, referred by the Ward Team to provide activities aid toward accomplishing those desired results. All mass and special activities, in general, aim toward programming for the prevention of deterioration and regression. The ward physician makes referrals after the Ward Team has reviewed the case and arrived at some decision as to the desired results on a special referral slip and affixes his signature to this.

The duty of each therapist is to work with all patients as they are referred to the program. He schedules all treatment programs at such times as patients are not involved in other schedules, such as industrial assignments, clinics, or the school program. Liaison is maintained with

other hospital personnel for facilitation in scheduling. The therapist is also responsible for the maintenance, repair, and care of equipment and facilities. He plans, schedules, and conducts special and holiday programs. He supervises volunteers from community and civic organizations when they are present to assist in the program, either regularly scheduled or specially planned. He interviews patients referred for treatment, reviews their case histories, and includes them in the appropriate program of his section. The Centralized Services therapist may attend diagnostic conferences or Ward Team conferences on the ward unit as rehabilitation services representative or as an interested party when special consideration is being given to a patient in his group. This is done with the approval of his immediate supervisor or the Supervisor of Rehabilitation Services. Each therapist within the section keeps accurate daily attendance records and thorough clinical notes on observation of patient reactions and responses in each activity. From these records, the monthly report mentioned earlier is compiled.

At Sonoma State Hospital, there are presently two Assistant Supervisors of Rehabilitation Services, one in the area of Ward Services, and one in the area of Centralized Services. One other position is included in the schematic setup of the Rehabilitation Department; that of an Assistant

Supervisor of the Industrial Therapy Section, who would have charge of the Group Leader Program and Industrial Therapists. The specific duties of the Assistant Supervisor of Rehabilitation Services differ somewhat between the two sections. Although both positions are classified as "working supervisors" who carry on some of the activities generally assigned to other Rehabilitation Therapists in the section, their general duties are in the area of supervising and co-ordinating the programs of the personnel assigned to the section. They supervise the clinical training of the student workers in this section. They stimulate participation by Nursing Service personnel in activities related to the section and provide guidance for these groups on individual projects. They counsel with each therapist individually as the need may arise. They cooperate with other hospital personnel in coordinating the activities of the section with other therapeutic programs. They attend supervisory and staff meetings in an effort to plan and evaluate the over-all program. They spend an average of thirty per cent of the work week in face-to-face contact activities with patients. They conduct a portion of the in-service training given in the institution. They supervise the programs of the other individuals of the section and observe such programs on occasion. They assist in the preparation of performance ratings for other members of the

section, and plan and conduct research activities when the opportunities arise. They are responsible for the ordering of supplies and equipment for the maintenance of a treatment program. They act for the supervisor at such times as requested or in his absence and correlate activities of their particular section with each of the other sections in a well-integrated program.

The Supervisor has many responsibilities. He is the direct supervisor of the Assistant Supervisor of Rehabilitation Services, the Co-ordinator of Volunteer Services, of the Industrial Therapist, Librarian, and Clerk Typists. The Supervisor develops and supervises a program for the rehabilitation of patients through his personnel who in turn organize individual and group therapy activities. His responsibilities include recruiting staff, making general work assignments, developing program principles and goals, correlating the services in the Rehabilitation Department with the other members of the Therapeutic Team, developing a plan for facilities and parks on the hospital grounds, preparing budgets, evaluating staff, preparing reports, and offering services where needed or required. Under medical direction, he develops and evaluates a general program for the rehabilitation of patients through the modalities of the department. He not only co-ordinates the department functions with the functions of other departments in the

hospital, but he co-ordinates the sections within his own department. He is the committee representative for the department and the reviewing officer for performance reports of therapists and group leaders. He is the actual rater on the performance reports for the clerk typists, Co-ordinator of Volunteer Services, Assistant Supervisor, Librarian II, and others who report directly to the Supervisor. He clarifies departmental procedures and is responsible for clearance and implementation of the department's program. He acts as a resource person in administration and makes reports and monthly summaries for the administrative heads. He participates in the in-service training program and acts as a counselor when needed. He develops through the necessary channels, the in-service training programs for departmental personnel and develops a training program for students from educational institutions. He develops relationships with local public and private agencies along with the Co-ordinator of Volunteer Services, and prepares the total budget data for the department. He is responsible for the morale of the department and for the rapport and interpersonal relationships between Rehabilitation Services, other departments, Nursing Services, and the administration of the hospital.

The Industrial Services Section has a line responsibility to the Supervisor of Rehabilitation Services and is

functionally responsible to the ward physician. The Industrial Therapy program is under the direction of the Assistant Supervisor of Rehabilitation Services. Included under Industrial Services is the group leader program which receives functional supervision under this program. Industrial Therapy is defined as the application of the concept of utilizing purposeful vocational placement as a tool in the training, rehabilitation, and evaluation of patients in the rehabilitation services program. The purpose of this section is to extend and plan the hospital work program along such lines that work placements will serve as a therapeutic agent to aid in the rehabilitation and training of mentally retarded patients. There is an effort to bring into industrial therapy as many patients as can possibly benefit by this type of program. The specific objectives of the industrial therapy program include training of patients in general work areas, training in specialized work tasks, progression or upgrading of patients in reality situations, development of responsibility of desirable work habits, increasing acceptance of responsibility, maintenance of maximum vocational potential, and increased self-esteem through successful job experiences.

The Industrial Therapist assigns patients to hospital industries in accordance with their psychological needs and physical limitations with the concurrence and approval of

the ward physician, nursing staff, industrial supervisors, and other professional personnel involved. Where a Ward Team is active, assignments are made in conjunction with the Team. The industrial therapist obtains the social control and psychological history of each patient before making an industrial assignment. He analyzes industrial jobs to be filled, compiles a job analysis survey of each hospital industry, describes the specific job, qualifications and supervision required. This would also involve conditions of the work and general impressions of the job as a training area. He visits wards, industries, shops, and treatment groups to ascertain if patients are available for industrial placement and to learn of patients' progress and interests. He plans treatment goals for specific patients with the Ward Team. He acquaints physicians and other personnel with opportunities for patient placement, evaluates patients' work progress in written reports, recommends change in assignment or release from assignment and informs social workers of patient participation in industrial therapy so that this information may be coordinated on the level planned.

Under the direct supervision of the industrial therapist, the Group Leader program functions as an effective psychiatric process. It draws upon the skills of psychiatrists, psychologists, social workers, ward personnel,

rehabilitation therapists, and other treatment team members. It is a developmental and motivational program to which patients are assigned to give them experience in a variety of activities in an attempt to hasten and develop recovery. Assignment of patients to the group leader program is for therapeutic gain only. Effectiveness of the group is measured in terms of patient improvement or progression. The specific jobs of the group leader program include utilization of the group process as an outlet for physical aggression, development, opportunity for socialization through a variety of activities, pre-vocational patient training, and opportunity for development of acceptable behavior patterns on a broader basis than is possible on the ward. The program provides a controlled situation in which patients' ability to accept responsibility can be developed and evaluated. It is subsequently designed also to prevent regression and deterioration of the continued treatment patient.

Each of the five group leaders has the responsibility of supervising one or more basic groups of patients. These basic groups are composed of the following categories of patients: (a) recently admitted patients referred for specialized group activities, (b) acutely ill patients who have progressed to a point where they are permitted off the ward, (c) chronically ill or disturbed patients who can

function only under group supervision, (d) patients with behavior problems who need specialized supervision and training, (e) pre-vocational patients for training and socialization jobs.

The group leader supervises groups of patients in selected off-ward activities. He provides leadership and motivation for patients to achieve therapeutic motivational and developmental objectives. He maintains clinical records of patients' progress and prepares reports on patients, group activities, special incidents, etc.

The Bibliotherapy section is located in the Activity Center and is under the direction of the Supervisor of Rehabilitation Services. The services of the patients' library are limited only by the patients who make use of this facility. The library provides materials to help patients who are able to advance themselves and to make life more pleasant for others. Children's books, magazines, scrap books, and greeting cards of all types are accepted by the library on a donation basis and distributed to the various wards of the hospital. Donation items which are distributed to the wards, are not generally returned to the library. Purchased books and materials, however, are filed and arranged alphabetically in an effort to include bibliotherapy in some small way as an educational aspect to the patient. Books are signed out in the same manner as they

would be in any normal public library. The librarian conducts pre-school story hours, primary reading sessions, and elementary picture association training classes. In many cases volunteer help is solicited in this area in an effort to expand the bibliotherapy section as a functional rather than diversional activity in the total rehabilitation program.

One of the most vital resources in the rehabilitation program is that given by volunteer services. The entire volunteer program is under the direct supervision of the Co-ordinator of Volunteer Services, who is in turn responsible to the Supervisor of Rehabilitation Services. The volunteer gives service by supplementing, not replacing, services given to the patient by the hospital staff. He provides additional resources unavailable to the hospital or increases the resources available to the hospital by supplementing community contacts. He assists the patient in bridging the gap between institutional and community life. He provides the patient with a more normal life within the institution. He increases the opportunity for the community to know and understand more about mental retardation, thus, hopefully, increasing community action and acceptance. He makes the hospital an active part of the community and the community an active part of the hospital.

The Coordinator of Volunteer Services provides active,

well-trained volunteers, where requested by the hospital, within the framework of the medical setting. She conducts surveys to determine hospital needs which can be supplied by volunteer workers, plans and conducts the recruitment and information program designed to interest the community residents in providing services. She develops an orientation program designed to acquaint volunteers with the history of mental retardation and illness, with the hospital program, and with the various types of treatment and behavioral characteristics of the patients. She arranges for in-service training in order to provide volunteer workers with the specific knowledge and skills to do their job. It is her duty to provide general direction of the volunteer workers, to supplement day-to-day supervision normally supplied by the section or department to which the volunteer is assigned. She keeps records of services rendered and arranges for appropriate recognition of these services. She addresses community groups and acts as the official liaison between the hospital and the community concerning volunteer services. She prepares material for use by newspapers, television and radio stations, describing hospital and patient activities in connection with the work of volunteers. In actuality, the coordinator of volunteers is responsible for all volunteer services given to the hospital. This does not imply that she is

exclusively responsible for all community contacts but it does require that the volunteer office be notified so that the hospital can be assured that all volunteer work with the patients meets the standards of performance established for volunteers and that their services are acknowledged.

It is the responsibility of the Coordinator to insure that volunteer groups are properly screened and trained, that the volunteer program actually supplements the hospital program rather than conflicting with it, that the volunteers abide by the standards and regulations established by the hospital, and that the volunteer program in no way conflicts with the hospital-treatment program. The Coordinator sets up proper channels, to give assistance to the staff in understanding the purpose and use of volunteers, and to provide volunteers with the opportunity for a successful and satisfying experience. In like manner, the hospital has a responsibility to be effective, as the volunteer services program must be accepted by the hospital. Therefore, adequate facilities should be provided.

The Coordinator of Volunteers is responsible for submitting a monthly report, including statistical and narrative sections, to the Supervisor of Rehabilitation Services. A monthly paper is mailed to the volunteers, recording volunteer services, changes in program, helpful hints on activities, and similar items, in an attempt to

increase communication between the hospital and community. The Coordinator also prepares a volunteer manual for orientation and in-service training of volunteers.

THE PLACE OF MUSIC IN REHABILITATION

The concern of many professional and laymen alike is to discover exactly where music therapy fits into the total rehabilitation program. By dealing with each of the allied therapies separately, a better understanding of rehabilitation as a whole and of the part which each of the allied therapies plays may be achieved. Music, as an adjunctive therapy, is of no more or no less importance than any of the foregoing therapies. Its contribution to the total rehabilitation program lies in its value as a medium or a modality. The degree of success with which music is used depends upon many extrinsic factors and variables not only with the therapist who is using this modality, but in the total hospital climate.

Music therapy is the use of music as an adjuvant therapeutic tool available to the physician who prescribes the total plan for helping the patient to better health. The underlying theory for music in therapy conforms to accepted principles of other adjunctive therapies. Where music therapy has been used in well-defined structured situations and with good imagination and flexibility by

well-qualified people, it has produced good results.

In a cooperative situation, such as the rehabilitation program at Sonoma State Hospital, the music therapist, or any other therapist for that matter, cannot isolate himself, his ideals, his particular type of implementation, in a world of his own. His success will depend upon the relative success of other members within his department. The success they see will reflect upon him and likewise the rapport he presents will reflect upon them. Rehabilitation is a combined effort of all therapists and personnel.

At Sonoma State Hospital, music plays a vital part in the total rehabilitation program. The Occupational, Recreation, and Industrial Therapists all use the modality of music in one form or another in many of their programs. The School Department and the teachers therein, use the modality of music in their teaching process with the blind and partially sighted, with the deaf and hard of hearing, and with the physically handicapped and mentally limited. Music is used in conjunction with simple arts and crafts, recreational games, and mass group activities such as birthday parties, "open-house," and gala outdoor festivities. Background music is used at Chamberlain and Butler hospitals, in the waiting rooms, in the ward units, and in the dining rooms. Everyone who is involved in rehabilitation is somehow involved in music, and likewise, everywhere

music is involved there may be therapeutic value.

Music reaches into almost every phase of therapy. Sufficient musical skills and understanding of the rehabilitation program prepare the therapist to cover a broad range of music activities. These are prescribed by the physician on a clinical basis and the music therapist must have an understanding of how to structure the music sessions to supplement or adhere to certain given goals. With the retarded groups, body rhythms are used along with simple musical games; for the physically handicapped, activities are included which improve muscle tone, increase strength, and develop coordination within the limitations of the patients.

(For a schematic table of organization of Rehabilitation Services, see appendix B.)

CHAPTER IV

BASIC PRINCIPLES, PROBLEMS, AND TECHNIQUES OF MUSIC IN THERAPY WITHIN THE CENTRALIZED AND WARD SERVICES SECTIONS OF REHABILITATION AT SONOMA STATE HOSPITAL

To discover some of the basic principles and techniques used in our music programs today and to fully understand the problems in the organization and administration of these programs, the writer has attempted in this chapter to discuss the present-day music programs. It is difficult to isolate principles and techniques as they relate to a specific program, without discussing the particular problems involved in that program. Likewise, it is difficult to attempt to elaborate on the specific problems of any program without relating to the techniques and practices which are to be used and which in turn may be the cause of some of these problems. Therefore, we shall consider principles, problems, and techniques as a total unit in this chapter.

As outlined in the previous chapter, Rehabilitation Services is subdivided into two main categories - the Ward Services function and the Centralized Services function. In the Centralized Services Division, there are two specific categories--the referred individual and group-treatment program, and the mas-group activity program. Any discussion

of the mass-activity programs must keep in mind that these are designed primarily on a recreational and diversional basis, rather than a purely clinical one.

The hospital dance orchestra, which numbers twelve, was first organized some years ago by three patients who worked at the hospital dairy. These three patients, Henry, Ray, and Louie, played banjo, harmonica, and drums respectively, and met during lunch periods and free evening hours to enjoy themselves and entertain other patients on their ward. They sang and played, using home-made and donated instruments, and soon gained prestige on the ward. They played and sang primarily because they enjoyed doing so and because they felt they could offer some of the other patients a limited amount of recreation and diversion. Soon afterwards other patients who were musically inclined, began joining the group and Henry had six amateur musicians with varying talents. This group, which he called the Dairy Band, was the start of an organized hospital dance orchestra.

Under the present-day setup, patients are encouraged to study individually and in groups, on various instruments, so that in time they may join the orchestra. The problem here, however, is a complex one. With a limited staff, including only two Music Therapists, it is impossible to find enough time to give private instruction to as many patients as could benefit from it. Very few instruments

are available and donations of valuable items such as musical instruments are few and far between, contrary to the belief that these items can be secured easily through donations. The basic problem, however, in giving individual and group instruction on instruments to prepare patients for the hospital orchestra, is the time element. These mentally limited people are extremely slow in learning and it takes a great deal of time to bring them to a level at which they can be admitted to an orchestra. Another problem which exists in giving private instruction, is the lack of facilities. There is no private, quiet place where individual instruction can be given and there are no private practice rooms where patients can go daily to work or study. Therefore, those patients receiving individual instruction do not have the opportunity to practice daily in order to improve on their instrument. Daily practice is certainly a criterion for the so-called "normal" individual who is attempting to progress musically on an instrument. The mentally limited, therefore, would need at least as much, if not more, consideration.

The organization, as it stands presently, meets twice a week for full band rehearsal. One evening is set aside for a two-hour rehearsal, and another evening is set aside for the weekly dance. On two afternoons, the music therapist conducts a series of individual and group instruction

taking the percussion instruments and melody group instruments in separate training sessions. This technique is used in the hope that the smaller groups can more readily absorb the fundamentals during these instruction periods and in turn, find it easier to incorporate what they have learned into the full band rehearsal. Therefore, in this manner, more time can be given to individuals within the smaller group and many of their specific musical problems can be worked out. Individual lessons are also given to the patients who are already in the orchestra, in an effort to encourage each patient to gain the greatest proficiency on his instrument, relative to his own limitation. In the end, this measure not only provides a better sounding group, but gives added impetus to the patient who is gaining in knowledge and proficiency, and offers him a real sense of accomplishment.

The techniques used during individual and group instruction and in the total group sessions, vary from time to time with the general hospital "atmosphere." Although definite limits and standards are set by the music therapist, a free permissive atmosphere is generally maintained. This offers the patient an opportunity to express himself creatively and musically and encourages initiative and self-government. Although the music therapist structures the program and encourages the patients, the group actually

functions under a patient leader. Somewhat like a modified therapeutic community, the patients in the hospital dance orchestra plan their own picnics and outings, select many of the songs to be played at the weekly dances, assemble their own equipment, and aid one another in the care and maintenance of instruments. They help audition new personnel for the orchestra and vote on acceptance or rejection of proposed playing engagements. They are often called upon to play for various ward parties and dances, Sunday afternoon musicales, monthly birthday parties, etc. They are considered by most of the hospital staff (and patients as well), as the "prestige group" of the hospital. Within the past year, new and additional equipment has been secured for the orchestra which provides them with the means for producing a better sound and the opportunity to progress more rapidly. Five new dance-band stands, which were made by patient orchestra members, add a professional touch to the group. With the addition of these things, they function more as an unified group in a more professional manner than before.

In an attempt to speed up the learning process and give the band personnel an opportunity to observe and actually play along with professional musicians, a volunteer program has recently been established. Each week two or three professional union musicians volunteer their time and

effort, under the direction of the Music Therapist, to help train and teach individual patients in the orchestra. These volunteers actually play along with the hospital orchestra at the weekly patient dances. This technique is used in an effort to build morale, to add prestige to the group, to give the group a more professional sound, and to offer the group a feeling of being a professional unit. There are many problems involved in such a program with volunteers, however. Through the Coordinator of Volunteer Services, these volunteers must be screened carefully to include only those individuals who are musically competent, who have an understanding and knowledge of this particular type of patient, who realize the limitations necessary in their service, who give of their time and effort without pay, and who gain rapport easily with patients and hospital staff. They must be dependable, sincere, and willing to cooperate with the Music Therapist within the scope of his established program.

The patient dance held each Wednesday night is also a mass group activity and a Centralized Services function. The music therapist in charge of the dance orchestra is also in charge of this weekly dance. Generally, twelve to fifteen units are represented at each dance, totaling approximately 450 patients. Although each ward unit sends one Psychiatric Technician to supervise the group, the Music

Therapist is directly responsible for the over-all activity and the success or failure of the dance. He works in close conjunction with the Psychiatric Technicians and with the supervising Psychiatric Technician responsible for general supervision. It is the responsibility of the Music Therapist to check with Nursing Services to make sure that the wards are notified of the dance, and that the supervising Psychiatric Technician in charge has assigned personnel to escort the ward units to the auditorium where the dance is held. The Music Therapist must also make arrangements for transportation to and from the dance for the dance orchestra personnel. He must clear security wards for those patients requiring special escort and supervision, and must make special arrangements for the orchestra personnel to arrive at the dance thirty minutes earlier and remain thirty minutes later, to enable them to set up their instruments and stands, and disassemble and store their equipment when the dance is finished. This is a necessary part of their training process.

The patient dance is primarily organized as a diversional program. It offers the patients an opportunity to socialize and offers facilities for emotional and physical release. This is often one of the few opportunities "boy-friend" has to meet "girl-friend." When special holidays or events occur, large scale dances are planned

and include extensive decorations, door prizes, spot dances, refreshments, and sometimes costumes. In most cases, the patients themselves help in decorating the auditorium and in serving refreshments, and take much pride in their ability to participate. It seems that the patients feel a great need to be of importance and to feel wanted or necessary. Activities such as these help satisfy these needs.

"Social Hour," an evening entertainment, is a structured mass-group activity supervised by Centralized Services. Each week four wards are selected (two male, two female) to participate in this function. The group generally numbers between 45 and 100 patients and the program is set up primarily as a recreational activity. The activity lasts for approximately two hours and is designed to meet specific needs of the patients. It includes such phases as organized group games and activities, group singing, dancing, bingo, etcetera. The purpose of this activity is primarily concerned with the socialization factor in rehabilitation. Many of the ward units are composed of a certain type, age level, and limitation. Within the hospital setup, ward personnel tend to develop their own groups and cliques. Many patients from one particular ward unit fail to realize the importance of being able to associate with other patients having lower I.Q.'s or more severe limitations than they possess. Certain male ward units tend to associate only

with certain female ward units and are reluctant to associate with girls from the other units. In selecting the four wards to participate in the weekly Social Hour program, the therapist in charge attempts to satisfy patient requests by combining male and female units which generally function well together. However, a definite effort is also made to combine male and female units which do not ordinarily function well together. When a group of this nature is brought together in this situation, the therapist in charge makes every effort to expose the patients to the value of this type social setting and incorporates within the evening's program recreational games and activities that fall within easy reach of an atypical group. This technique lends itself well to this situation and does not force individuals to pair up or lose identity within their own group. As time continues, the barrier which these patients have placed between themselves gradually disappears and a program demanding closer individual association can be planned and executed.

With similar groups of atypical wards which have progressed to the point of social acceptance of one another, possibilities of education and training arise. For example, when a section of time is allotted to dancing, the therapist may choose to teach the boys the proper method of requesting a dance from a girl; the proper way for a girl to accept a

dance from a boy; the correct procedure for a boy to use in returning the girl to her chair after the dance, or a graceful way for a girl to refuse a dance when requested. These may seem like trivial items in the total hospital's treatment program, but these are real problems to the teen-age patient who recognizes them as such.

The monthly birthday party, held on the third Saturday of each month, is designed for all ambulatory patients in the hospital whose birthdays fall within a particular month. This is a mass-group activity and a Centralized Services function. Although it is not designed as a specific music activity, there is generally some music in the over-all program, including the performance of the hospital dance orchestra, which plays each month for this affair. These patients at Sonoma State Hospital are not unlike our so-called "normal" children and desire personal recognition whenever possible. Most of the patients are aware of the significance of birthdays and derive a definite amount of satisfaction in being able to attend the monthly birthday party, at which they are recognized individually. Each patient is called by name to the stage and given a birthday gift. This is the highlight of the program. Secondly, but by no means less important, is the huge birthday cake and the group singing of "Happy Birthday." Around this center of attraction in the program,

recreational games and dancing are provided and all patients present are encouraged to participate.

Oftentimes, though not each month, volunteer groups come to the hospital to sponsor these monthly birthday parties. These groups work in conjunction with the therapist in the execution of the program which the therapist had previously planned. Occasionally, the volunteer group brings in semi-professional entertainment and additional refreshments or gifts, which the patients welcome and enjoy. A program such as this not only provides the feeling of belonging and recognition mentioned above, but affords entertainment and diversion for the patients as well.

Probably the largest mass groups handled by Centralized Services are those involved in the special-events activities. These events would include such activities as Easter parties and dance, Easter bonnet parade, Christmas parties and song-fests, Christmas pageant, 4th of July celebration and fair, "open-house," Memorial Day activities, Thanksgiving Day festivities, Halloween costume dance, Valentine's Day King and Queen Ball, and the New Year's Eve Dance. These special-event activities generally include much planning, coordination, and organization on the part of many therapists within the department. The activities are generally gala events, involving elaborate decorations, costumes, refreshments, and entertainment. A team of

therapists, under the direction of a chairman, work out the problems involved in planning large-scale events which would include as many as 1500 patients. Scheduling, coordination, integration of programs, clearance with Nursing Services, enlisting of technician help for supervision, and approval from doctors, ward units, psychologists, and Social Service are all part of the over-all program planning.

Where food and refreshments are to be served, the therapist in charge must make arrangements with food service weeks before the activity is to take place in order to be assured of adequate refreshments. If the activity involves off-grounds transportation, he must clear with Social Service, Security, transportation, and ward physicians and personnel at least two weeks in advance. These clearances must be made by memoranda (in writing) and must be double-checked by phone two or three days in advance of the activity. The therapist must clear with other departments such as school, psychology, and social service to be sure that the activity does not conflict with other programs, clinical demonstrations, or the like. He must make arrangements for the use of the facilities wherever the activity is to be held and appoint decorating, refreshment, and clean-up committees. Although these generally consist of patients, the therapist is directly responsible for their supervision.

Occasionally special events must be cancelled because of mass illness on the ward, lack of Nursing Service personnel for supervision, bad weather, or illness on the part of the therapist in charge. Because of the fact that Rehabilitation Services Department at Sonoma State Hospital is understaffed, each therapist carries a maximum load and it is sometimes impossible for another therapist to take over a special event program for the one who is ill. This would necessitate cancellation of the program. Supervision at mass group activities is an important factor. Under the present hospital organization all patients must be personally escorted anywhere on the hospital grounds after the hour of 4:30 p.m. Therefore, when Nursing Services is short on personnel for some reason or other, many patients are deprived of the opportunity to attend such a program because the ward unit cannot spare a technician for escort purposes. If this situation is true of several wards, the activity must be cancelled. During the winter months when rain and bad weather prevail, patients must be transported to and from the place of activity in the hospital bus. On occasion, this vehicle is under repair or being used for priority purposes and cannot be used for on-grounds transportation. Because there is no other means of transportation, at such times the activity must be cancelled.

There are innumerable problems other than these which

confront the therapist in planning a large scale special event, but which would not be expedient to discuss in detail at this point.

On many of the special holidays, off-grounds activities are planned. Selected groups of patients are taken both day and evening to such affairs as the Ice Follies, baseball games, concerts, fairs, circuses, musicals, etc., in an effort to expose the patient to the "outside world." This technique is used primarily to involve the patient with so-called "normal" people as often as possible to give him opportunities to relate to normal living situations. At these off-grounds events, he is given spending money to use at his own discretion and an opportunity to mingle and associate with other people. In this manner, he learns to accept personal responsibility and derives a sense of individuality, a feeling of independence, and an air of capability. He soon learns that he is not so different from other people and in most cases that he is generally well accepted. Educationally, these outside affairs broaden horizons of learning and help develop new interests. Often these events are an aid in revealing to the patient the fact that the "outside world" is less threatening and less foreboding than it previously seemed. The problems involved in off-ground activities include the requesting and securing of bus transportation, the

requesting and allotting of patient funds, the supervising of the activity (one therapist or technician for each ten patients), the clearing of wards, doctors, Social Service, and Security.

Folk dancing, though a Centralized Services function, has been directed by the Ward Services music therapist. Three separate sessions, of one hour each, have been held on Friday evenings for ten different ward units.

The primary objective of this activity is in the area of socialization and is designed as an outside-type, leisure-time activity. In this manner, those patients who are discharged to family care or work placement situations, may add folk dancing to their repertoire of leisure-time activities. Those who remain in the hospital often associate more readily with the "outside world" through the medium of these accepted activities. It is diversional in nature as well, and affords to a large group of patients an interesting evening activity which calls for concentration, physical exertion, body motion, and social awareness. Classes are held for beginning, intermediate, and advanced students and afford learning experiences in following directions, maintaining self-discipline, and improving retention.

Originally the groups were arranged to accommodate a three-phase program involving beginning, intermediate, and

advanced classes. The program is adapted to the specific limitations of the patients involved, and usually begins with elementary musical chairs and a simplified grand march, and progresses to the Virginia Reel and the Oklahoma Mixer. With more advanced groups, the limit of perplexity would vary according to the over-all group ability. Those in the advanced groups may progress even beyond this point to relatively complex patterns involving circles and squares. Directions are usually simplified, and in many cases it is necessary to simplify and demonstrate in detail again and again. Repetition by means of measure groupings in the music is a common and satisfactory practice in use. Often a beginning or intermediate group may fail to understand these simple directions. One technique that has been used with a relative degree of success is to have one or two patients (who do understand) give the directions to the rest of the group in their own terminology and at their own verbal level. Sometimes the therapist in charge is unaware that the terminology he is using (though common to him) is above the level of understanding of the patient.

Patients who seem to progress adequately in the elementary and intermediate groups, normally "graduate" to the advanced group. There is much prestige involved in belonging to the advanced group, since it is in this group that patients may associate with the "higher-grade" boys and

girls. This creates somewhat of an incentive within the two primary groups and aids in the expediency in learning.

There are many problems involved, however, in such an activity as this. Because of limited space and facilities, there is little or no opportunity for the patients to practice between learning sessions. As a result of this, almost half of each learning session must be spent in reviewing what was learned at the previous session, since there is very little "carry-over" with these patients. Dances must be retaught at each meeting and progress is very slow. Another problem in and of itself, is getting the patients interested enough to listen carefully to the music. The problem of transferring what is heard as musical stimuli into concrete body movements seems insurmountable and the normal record speed seems too fast for the patients to learn by; 78 rpm records may be played at 45 rpm, and 45 rpm may be played at 33 1/3 rpm, but this technique is not altogether satisfactory. Training records specifically designed to meet the educational needs of patients in this area should be available, along with audio-visual materials and live-group demonstrations by professional personnel.

The Ward Services also carries on specific programs on separate ward units in the hospital setting. These programs are determined as to type by the particular ward on which they are given. The hospital is divided into an

imaginary dual setup; the custodial side and the therapeutic side. The custodial side maintains those cottages such as Cromwell, Brent, and Poppe, and the main emphasis of music therapy would point toward making these patients better citizens at the hospital. The program is designed to teach meaning of concept, promote command of words, create associations, prevent further regression and deterioration, and help keep bodies active. In the main, these patients are not expected to leave the hospital situation; while on the other side, music plays an important part in fitting patients to go out into the community. There are intermediate steps, however, which must be taken into consideration such as preparing youngsters for school through pre-school activities. In such a situation, recorded sessions are generally most successful with activity records involving finger play, circle games, and educational material. The impetus and carry-over of such a program depends largely upon the ward doctor and the ward personnel.

Other Ward Services programs involve: treatment programs on Poppe and Stoneman, games and rhythms on Slater and Stoneman, supervised play on Brent and Bane, general music on Paxton, Oak Lodge, Osborn, Haven, and Lathrop, and listening programs furnished to Dunbar and Roadruck.

These listening groups were designed to create a social situation which could stimulate social interaction

while patients remained in the institution, and simultaneously stimulate interest in activities in which patients might participate safely after discharge. Realizing that experience with music makes its contribution toward appreciation rather than in tangible results, it is most important to stress a positive situation; that is, starting from the patients' level and providing musical experiences which would allow a gain in basic information, rather than retention of facts or technical knowledge.

The general music activity has been organized to give an opportunity for active participation for patients who have few other opportunities because of their intellectual limitations. Activities are necessarily very simple, are repeated many times, and are planned at a level that excludes no one from some kind of participation. Material is used to develop identification of animals, colors, and objects; to develop ability to follow simple directions, distinguish between right and wrong, imitate actions, and practice cooperation in group activity. Time is allowed for individual expression through singing, dancing, reciting, and sharing.

The mentally retarded need more motivation through improvisation and dramatization than other children and music certainly plays an important part toward this goal. A short attention span and need for individual help characterize

these people. Therefore, many independent activities are helpful. Group activities are held for short periods many times throughout the day and many authorities feel that music can be used to improve attention and counteract distractability and tension. Because this group participation is found in simple singing games and other rhythmic activities such as clapping, swinging arms, and playing rhythm instruments in time to a well defined beat, these techniques are used in most of the ward services programs. Movement becomes easier than verbalization among the retarded and rhythmic activities of the "follow-the-leader" type are good. The ward therapists realize that music has certain values that coincide with their contribution to the over-all values found in daily living. He plans the patients' experiences with these values in mind and therefore, the quality of musical experience and the quality of daily living is enriched. Certain immediate values are found in release from tensions and opportunities to express emotions, while long-term values are found in esthetic appreciation and achievement of security. The therapist recognizes that no two people are alike. They differ in the degree of response to music and in the kinds of musical experiences that appeal to them. Theory seems to approach reality when these experiences are enjoyable and come from direct active exploration with music and when they provide

an individual level of success for each patient.

Though it is quite impossible for the ward therapist to plan adequate programs on all units, he attempts to provide as many patients as time allows with the basic music materials which meet need fulfillment. Through this variety of musical experiences, the patient has an opportunity to grow socially, physically, mentally, and spiritually, but often ward situations prohibit a well-rounded program. In some instances, the therapist may be compelled to give a group of patients only a part of the total program he feels they need. Consequently, the variety of inter-related musical activities cannot be presented and the patients may not be given the opportunity to explore areas of music such as singing, instrumental, rhythmic, listening, and creative activities. Whenever this ideal situation does present itself, however, the patient has a chance through group and individual activities to participate to the degree of his ability and in the way he desires. As the patient participates in musical experiences which are related to his hospital and daily living, he grows in sensitivity to the musical beauty around him, and becomes aware of the contribution music can make to his daily life. Finding pleasure and satisfaction in his music activities within the institution, he may search for further musical opportunities outside the hospital after discharge.

In conclusion, it may be said that the general ward music program can be categorized as follows: the general music program, the listening program, the singing program, the dramatic and creative program, and the instrumental and rhythm program.

General music program. As explained above.

Listening program. Worthwhile mental attitudes such as attention and concentration can be developed by listening activities. Good listening is more than an act of passive reception. It is the active use of mind and imagination in responding to ideas expressed in music; in what the patient hears and interprets, then responds and expresses. The most popular type of listening seems to include familiar melodies, melodies that are simple and song-like, music with sheer beauty of tone, music which strongly suggests moods, music with a constant rhythmical pattern, and story music. The atmosphere for good listening should be a friendly, happy, and comfortable one. A variety of music should be used to counteract the short attention span and on some occasions, the patients may hum the melody, clap to a rhythm, make comments, or ask questions. The therapist must be attentive and engrossed in the listening activity himself to inspire the patients to follow his example to the best of their ability.

Singing program. Singing is the basic activity in any well balanced hospital program. Though the Centralized Services therapist may use this medium of expression to a greater degree with the mass group activity, the ward therapist generally tries to incorporate singing into his program. (Singing is especially helpful as a means of communication. It gives the patient a better command of his expressive actions and develops feelings of kinship and security. Singing, like talking, is learned best in social situations where each patient is given an opportunity to take part at his highest level of ability. Any person can learn to sing only by singing.

The music therapist should choose songs which contain elements of familiarity. The range should not be too wide and the key should be within easy vocal range of the group. The rhythmical flow should have life, lilt, and consistency, and there should be a group correlation between the word sounds and word rhythm, and the tonal setting of the music. These words should have meaning at the patients' level. The therapist must maintain a sympathetic understanding of the varying degrees of musical development in the patients, and should be able to sing along with them.)

Dramatic and creative program. Dramatic and creative possibilities are present in almost all musical selections

in which the patients participate. They may act out simple songs, records they listen to, or occasionally, they can interpret with their own ideas. The patients may suggest their own ideas on dramatic or creative possibilities. These activities can help develop better coordination of body movements and personal poise with their peers.

Instrumental and rhythm program. The instrumental and rhythm activities include experiences with both rhythm and melody instruments. The rhythm instruments may include drums, maracas, cabacas, guiros, claves, rhythm sticks, sand blocks, triangles, jingle clogs and bells, tambourines, castanets, cymbals, and the kameso. These may be used to accompany or imitate rhythmic patterns, as well as to accent rhythmic pulsations. The melody instruments may include bells, auto harps, pianos, xylophones, tonettes, song flutes, and harmonicas. This, however, does not limit exploration of other possibilities. Simple rhythm bands or individual instruments may be used to augment a recorded musical selection. The instruments may also be used with group singing, remembering to use them as an accompaniment secondary to the singing. Sometimes the therapist may find it functional to use these instruments with rhythmic activities such as dancing and bodily response to creative rhythms. In actuality, the rhythm instruments should be

used for beat, accent, mood, and incentive to rhythmic expression. The melody instruments, however, can only be used on the level that patients are able to acquire competency. The piano may be used for a few simple chords, but is often used for melody with one finger only, and is generally best handled by the therapist himself. Song flutes, recorders, tonettes, and the like may be used for simple melodies with a range not exceeding one octave.

Rhythms occur in everyday living and are an integral part of each patient's life. Rhythmic activities should be kept happy and free, not serious and stiff. In the ward programs, best success has been achieved through a relatively permissive program.

A selected list of song titles, including sources and suggested ways of presentation, are included in the appendix, including story songs, finger play songs, rhythm songs, singing game songs, folk songs, action songs, and patriotic songs.

CHAPTER V

SUMMARY

The problems under consideration in this thesis were (1) to discover the nature of music in therapy, its history, and its present day use; (2) to discover the type of patients at Sonoma State Hospital and their general needs in terms of Rehabilitation Services; (3) to discover the scope of the total rehabilitation program at Sonoma State Hospital and the part which music therapy plays; (4) to discover the general principles, problems, and techniques of music therapy used at Sonoma State Hospital.

A great many people have felt the need for more research and investigation in the field of music therapy with special emphasis on the use of music with the mentally deficient or physically limited child. A critical and exhaustive investigation on the hospital level could aid in determining the worth and value of music as an universal tool and medium in social adjustment. More important, it could help establish a clarity of thought, language and rationale in regard to the principles, methods, and problems of music in an institution where it plays a role in therapy and rehabilitation.

Since the specific uses of music therapy are discussed at great length in the preceding chapters, the writer

will attempt in the final pages of the summary to (1) evaluate the total music program at Sonoma State Hospital, and (2) make certain recommendations for improvement.

In evaluation, it would seem that the future goal of the Rehabilitation Therapy Department at Sonoma State Hospital should be to emphasize further the individualization of the patient. The administration, supervision, and section coordination might all well tend toward the area of individualization of the single patient. Though this concept is not a new one, it is one which the writer feels therapists need to know more about, especially in the working situation. In the past year, the program has been more general than individual, primarily because of a low ratio of therapists to patients. At that time there were two recreational therapists, three occupational therapists, three music therapists, one cosmetic therapist, and one librarian, whose time was split between the medical library and the patients' library. It is estimated that the patient load, within the next year, will increase to over 4000, thus augmenting the service needs of each section.

In the music therapy section specifically, one position was eliminated from the allowance of this section of rehabilitation therapies, thus forcing the section to curtail certain activities on the individual level. There has also been a large turnover of personnel in the department

As such changes take place, a complete re-evaluation of rehabilitation activities might well be made.

One of the most encouraging developments seen in the music therapy section has been the increasing use of referrals on the part of physicians, psychiatrists, and ward teams in requesting inclusion of patients in activities of the music section. This social prescription, which includes information of the patient's needs and abilities, is very helpful to the music worker, but has not been utilized to its fullest extent in the past. Because of this development in prescription referral, programs were resumed on five ward units previously served by the music section, and new programs were started on eight ward units where former therapists had not worked with music. These thirteen programs offered combined listening, singing, and rhythmic activity experiences to a total of about 700 patients, most of whom received very few other special contacts.

The author recommends (1) that a greater emphasis be placed on long-range programming and a more concentrated effort be exerted in the use of existing facilities; (2) that accurate records be kept by each therapist and retained by the new therapist who is coming in; (3) that these records be studied carefully and plans made in conjunction with the other therapies to carry on the existing programs; (4) that new programs be organized according to a master plan, and

wards encouraged to supplement their social activities and therapeutic programs; (5) that a closer coordination with nursing services be maintained at all times in planning rehabilitation activities.

The State Department of Mental Hygiene has indicated a trend away from work in a particular area using a specific tool, to a more generalized frame of reference. In this line of thinking, there would be no such category as music therapist, occupational therapist, recreational therapist, and the like. Rather, each would be called rehabilitation therapist. This would necessarily require that each individual within the rehabilitation department be able and obligated to carry on therapy programs outside of and including his own specialty area.

A thorough study at the state level, evaluating the pros and cons of this question, might well be justified.

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APPENDIX

APPENDIX A

RECOMMENDED SONGS

A. ACTION

SONG TITLE	SOURCE	WAYS OF PRESENTATION AND USE
CLAP YOUR HANDS	American Folk Songs, p. 86.	ACTION. Follow the leader song. Children without physical handicaps may do many improvisations--clap hands, stamp feet, tap toes, nod heads, etc. Physically handicapped children may nod head, stretch up high, shake hands, etc.
COUNTING SONG	Music for Early Childhood, p. 8.	FINGER PLAY. Use recording in album <u>Music for Early Childhood</u> MJV 141.
DANCE, THUMBKIN, DANCE	Music for Early Childhood, p. 44.	FINGER PLAY. Use recording in album <u>Music for Early Childhood</u> MJV 141. Younger mentally retarded may use puppets. Tone bells playing "G, n nD, n" may provide an introduction.
DID YOU EVER SEE A LASSIE	New Music Horizons II, p. 143 Happy Singing, p. 143	SINGING GAME. Use recording from RCA Album E87.

SONG TITLE	SOURCE	WAYS OF PRESENTATION AND USE
WEECY WEENCY SPIDER	American Folk Songs for Children, p. 126. The First Grade Book, p. 159.	FINGER PLAY. Good for younger children, all groups. Fingers are a spider, climbing up a spout--hands fall, palms down, etc. Play record from Album 13, <u>Our Singing World</u> .
FOUR IN A BOAT	Folk Songs of the U.S., p. 2. Our Land of Song, p. 128.	FOLK GAME. Middle and upper grade Mentally Retarded. Add rhythm instruments.
HERE WE GO ROUND THE MULBERRY BUSH	First Grade Book, p. 49.	IMPROVISATIONS. "This is the way we ride the bus" or "Here we go round the birthday cake." Put words, brush, teeth, comb, hair, tie, shoe, etc., on flash cards which may be used on flannel board as a part of sight vocabulary.
I'M A LITTLE TEAPOT	First Grade Book, p. 7.	DRAMATIZATION. Young Mentally Retarded. <u>"I'm a Little Teapot"</u> --Columbia 368 PV.
INDIANS IN A TEPEE	Singing Fun	FINGER PLAY
LONDON BRIDGE	New Music Horizons I, p. 4. Experiences in Music for First Grade Children p. 98.	SINGING GAME

SONG TITLE	SOURCE	WAYS OF PRESENTATION AND USE
LOOBY LOO	Experiences in Music for First Grade Children p.98. Happy Singing, p. 150. Sing and Play Book, p.76. First Grade Book, p. 50.	FOLK GAME. Recommended for Mentally Retarded.
LITTLE RED WAGON, THE (Old Brass Wagon)	Songs to Grow On, p. 70.	RHYTHMIC ACTIVITY. Rhythm instruments--improvise by adding verses. Use recording of "Old Brass Wagon" in Music for <u>Early Childhood Album</u> MJV 141.
NICK NACK PADDY WACK	First Grade Book, p. 44. Singing on Our Way, p. 7. New Music Horizons II, p.120. Songs to Grow On, p. 98. Music for Early Childhood, p. 43.	RHYTHMIC ACTIVITY. Use hand clapping, drum or other rhythm instruments--improvise words for other numbers. Use record from Album 1A, <u>Our Singing World</u> .
OPEN, SHUT THEM	Songs for the Nursery School, p. 8.	FINGER PLAY. Young Children, all groups.
PAW PAW PATCH	Singing Everyday, p. 51. Music for Early Childhood, p. 27. Songs to Grow On, p. 116. Folk Songs of the U.S., p.4.	FOLK GAME. Use recording in Album 22, <u>American Folk Songs (Follett)</u> . Play record from Album 4A <u>Our Singing World</u> .

SONG TITLE	SOURCE	WAYS OF PRESENTATION AND USE
SHOO, FLY, DON'T BOTHER ME	Songs to Grow On, p. 108. New Music Horizons V, p.92.	FOLK SONG. See directions, <u>Songs to Grow On</u> , p. 109-- especially recommended for Deaf and Hard of Hearing. Use recording <u>Allegro AK58</u> .
SKIP TO MY LOU	Folk Songs of the U.S., p.1. Songs to Grow On, p.104. American Folk Songs for Children, p. 166. Singing Any Rhyming, p.44.	RHYTHMIC ACTIVITY & IMPROVISATIONS. All groups. Use recording "Skip to My Lou" in Play Party Album (Decca) for Deaf and Hard of Hearing. Add verses such as "Going to the Circus," "I'll see the monkeys," etc. Sing with autoharp in Key of C-- add rhythm instruments.
TEN LITTLE INDIANS	First Grade Book, p. 43. Physical Education in the Elementary Schools, p.453.	FINGER PLAY
WHERE IS THUMBKIN?	Kindergarten Book, p. 51	FINGER GAME. Mentally Retarded and Cerebral Palsied. Use recording from Album K, <u>Our Singing World</u> .
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B. COMMUNITY		
LITTLE BROWN CHURCH	Music In The Air, p. 215 Happy Singing, p. 34. New American Song Book, p. 82. Kindergarten Book, p. 69.	RHYTHM INSTRUMENTS. Older Mentally Retarded.

SONG TITLE	SOURCE	WAYS OF PRESENTATION AND USE
MERRY-GO-ROUND	New Music Horizons I, p.8. Experiences in Music for First Grade Children, p.90. First Grade Book, p.34.	DRAMATIZATION. Young children. Recording from <u>New Music Horizons I</u> , MJV 76. Show pictures or stuffed animals.
MUFFIN MAN	New Music Horizons II, p.72. Songs to Grow On, p. 99. First Grade Book, p. 75.	IMPROVISATIONS. "The Fireman, the popcorn man, the ice cream man, the milkman" etc. For small children, play the game described in Songs to Grow On, p. 99. Play recording "The Muffin Man" from Album 1A, <u>Our Singing World</u> .
C. FOLK		
BAND OF ANGELS	Songs to Grow On, p. 54	USE INSTRUMENTS. All groups. In Chorus use one instrument on each day of the week. Substitute "Monday," "Tuesday," etc. for "Sunday."
BILLY BOY	Folk Songs of the U.S. p.31.	
BLUE TAIL FLY (Chorus)	Folk Songs of the U.S. p.30. Songs to Grow On, p.42.	USE INSTRUMENTS. Middle and upper grade Mentally Retarded. Recording in Album 22, <u>American Folk Songs</u> (Follett).

SONG TITLE	SOURCE	WAYS OF PRESENTATION AND USE
CLEMENTINE	Music in the Air, p. 218.	DRAMATIZATION AND IMPROVISATION. Older Mentally Retarded. Use autoharp and rhythm instruments.
DOWN IN THE VALLEY	Folk Songs of the U.S., p. 32. New Music Horizons VI, p. 26.	For older Mentally Retarded and Physically Handicapped. Use flannel board, with separate lines of song added one at a time as it is presented.
EENCY WEENCY SPIDER	American Folk Songs for Children, p. 126. Singing On Our Way, p. 9.	FINGER PLAY. Good for younger children, all groups. Fingers are a spider, climbing up a spout--hands fall, palms down, etc. Play record from Album Ib, <u>Our Singing World</u> .
FOOBA WOGBA JOHN	Folk Songs of the U.S., p. 12. New Music Horizons IV, p. 35.	Middle and upper grade Mentally Retarded use recording from Songs from New Music Horizons IV Album MJV 135. Use autoharp, key of C.
FOUR IN A BOAT	Folk Songs of the U.S., p. 2. Our Land of Song, p. 128.	FOLK GAME. Middle and upper grade Mentally Retarded. Add rhythm instruments.
GOODBYE OLD PAINT	American Folk Songs for Children, p. 62.	Use pictures of cowboys and horses.

SONG TITLE	SOURCE	WAYS OF PRESENTATION AND USE
GO TELL AUNT RHODIE	Songs to Grow On, p. 28. Folk Songs of the U.S., p. 27.	Middle and Upper grade children use autoharp. A tongue depressor to stroke harp is recommended for handicapped children.
HOME ON THE RANGE	Singing in Harmony, p. 11.	Deaf and Hard of Hearing use recording Album 22, <u>American Folk Songs</u> (Follett). <u>Older Mentally Retarded</u> may add instruments.
JACOB'S LADDER	Music In The Air, p. 228. Folk Songs of the U.S., p. 8.	Middle and upper grade Mentally Retarded and Physically Handicapped.
OLD FOLKS AT HOME	Happy Singing, p. 8. New Music Horizons VI, p. 180.	Use recording from Album 22, <u>American Folk Songs</u> (Follett).
OLD MC DONALD	Singing Every Day, p. 14. Singing and Rhyming, p. 136.	Good with all groups. Use flannel board with pictures of animals. Use recording "Old McDonald" from Album 3A, <u>Our Singing World</u> .
PAW PAW PATCH	Music for Early Childhood, p. 27. Songs to Grow On, p. 116. Singing Every Day, p. 51. Folk Songs of the U.S., p. 4.	FOLK GAME. Use recording in Album 22, <u>American Folk Songs</u> (Follett). <u>Play record</u> from Album 4A, <u>Our Singing World</u> .

SONG TITLE	SOURCE	WAYS OF PRESENTATION AND USE
POLLY WOLLY DOODLE	New Music Horizons IV, p. 8. Music In the Air, p. 225. New American Song Book, p. 120.	USE INSTRUMENTS. Middle and upper grades; all groups. Therapist sings first and third lines of song, children play "Polly Wolly Doodle All the Day," All sing chorus.
POP! GOES THE WEASEL	Happy Singing, p. 82. Singing Every Day, p. 50.	"Pop" may be sounded by using different instruments. Use recording from Album 22, <u>American Folk Songs</u> (Follett). May be used as a folk game with ambulatory children.
ROW, ROW, ROW YOUR BOAT	Music in the Air, p. 222. The First Grade Book, p. 127.	PANTOMIME.
SHE'LL BE COMIN' ROUND THE MOUNTAIN	American Folk Songs for Children, p. 90. Music in the Air, p. 18. We Sing, p. 162.	ACTION. "Toot, toot," "Whoa Bill" and "Hi, Babe" may be done by older children in all groups.
SHOO, FLY, DON'T BOTHER ME	Songs to Grow On, p. 108. New Music Horizons V, p. 92.	FOLK GAME. See directions, Songs To Grow On, p. 109. Recommended for Deaf and Hard of Hearing. Use recording, Allegro AK 58.

SONG TITLE	SOURCE	WAYS OF PRESENTATION AND USE
THIS IS THE WAY WE WASH OUR HANDS	Songs for the Nursery School, p. 100.	IMPROVISATIONS. Flannel board-- pictures of soap and towel, tooth brush, comb and brush, etc. Children make up addi- tional verses.
THREE BLIND MICE	Singing and Rhyming, p. 146. New Music Horizons III, p. 69.	PANTOMIME. Hold up three fingers for "three," put hands over eyes for blind and point to picture of mouse for "mice." Fingers moving quickly show "See how they run." Use pictures of farmer's wife.
YANKEE DOODLE	The First Grade Book, p. 105 Singing and Rhyming, p. 12.	DRAMATIZATION. Younger Mentally Retarded and Cerebral Palsied.

D. NURSERY RHYMES

BAA, BAA BLACK SHEEP	New Music Horizons II, p. 108. First Grade Book, p. 155.	DRAMATIZATION.
HICKORY DICKORY DOCK	New Music Horizons II, p. 6. Singing and Rhyming, p. 154.	DRAMATIZATION. Tone block or sticks play clock rhythm-- triangle play "one." When used with Orthopedically Handicapped, one child may hold triangle, another child strike it.

SONG TITLE	SOURCE	WAYS OF PRESENTATION AND USE
HOT CROSS BUNS	Experience in Music for First Grade Children, p.103. New Music Horizons II, p.33. Songs for the Nursery School, p. 75.	Use melody bells in all groups. Single resonator bells recom- mended for Cerebral Palsied.
LAZY MARY	New Music Horizons II, p. 30.	RESPONSE. At conclusion of rest time the therapist may sing, substituting names of children in the group. As each child's name is sung he gets up.
MARY HAD A LITTLE LAMB	New Music Horizons I, p.12. New Music Horizons II, p.33. Experiences in Music for First Grade Children, p.102. Songs for the Nursery School, p. 85. Singing All the Day, p.26.	Use flannel board and pictures with young Cerebral Palsied and Mentally Retarded.
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<u>E. PETS AND ANIMALS</u>		
BARNYARD SONG	Songs to Grow On, p. 76.	Use flannel board with pictures of a tree, cat, duck, cow, hen, etc. Therapist sings "I had a cat" placing animal picture on board. Boys and girls sing "cat goes fiddle dee dee." Repeat same idea for each animal involved. Use recording from Album 4A, <u>Our Singing World</u> .

SONG TITLE	SOURCE	WAYS OF PRESENTATION AND USE
BAA, BAA, BLACK SHEEP	New Music Horizons II, p.108. First Grade Book, p.155.	DRAMATIZATION
CHASE YOUR TAIL, KITTY	Songs for the Nursery School, p. 25	Young Cerebral Palsied may improvise by changing "kitty" to "doggy," singing only the first half of the song. Another improvisation might be--"chase the ball, Johnny." Young Mentally Retarded children may go round and round on hands and knees imitating a kitty or a doggy, or a boy chasing a ball.
WEENY SPIDER	American Folk Songs for Children, p. 126. The First Grade Book, p. 159.	FINGER PLAY. Good for younger children, all groups. Fingers are a spider, climbing up a spout--hands fall, palms down, etc. Play record from Album 1B, <u>Our Singing World.</u>
MARY HAD A LITTLE LAMB	New Music Horizons I, p.12. New Music Horizons II, p.33. Experiences in Music for First Grade Children, p.102. Songs for the Nursery School, p. 85. Singing All the Day, p. 26.	

SONG TITLE	SOURCE	WAYS OF PRESENTATION AND USE
MY LITTLE PONY	New Music Horizons I, p.26. Experiences in Music for First Grade Children, p.84.	Imitate hoof sounds with tone block or cocoanut shells.
OLD MAC DONALD	Singing and Rhyming, p.136.	Play recording "Old MacDonald" from Album 3A, <u>Our Singing World</u> . Imitate animal sounds. Use flannel board and pictures of each animal. Children take turns using flannel board. They may add stanzas about other animals.
THREE LITTLE KITTENS	New Music Horizons I, p.6. First Grade Book, p. 80. Experiences in Music for First Grade Children, p.100.	DRAMATIZATION

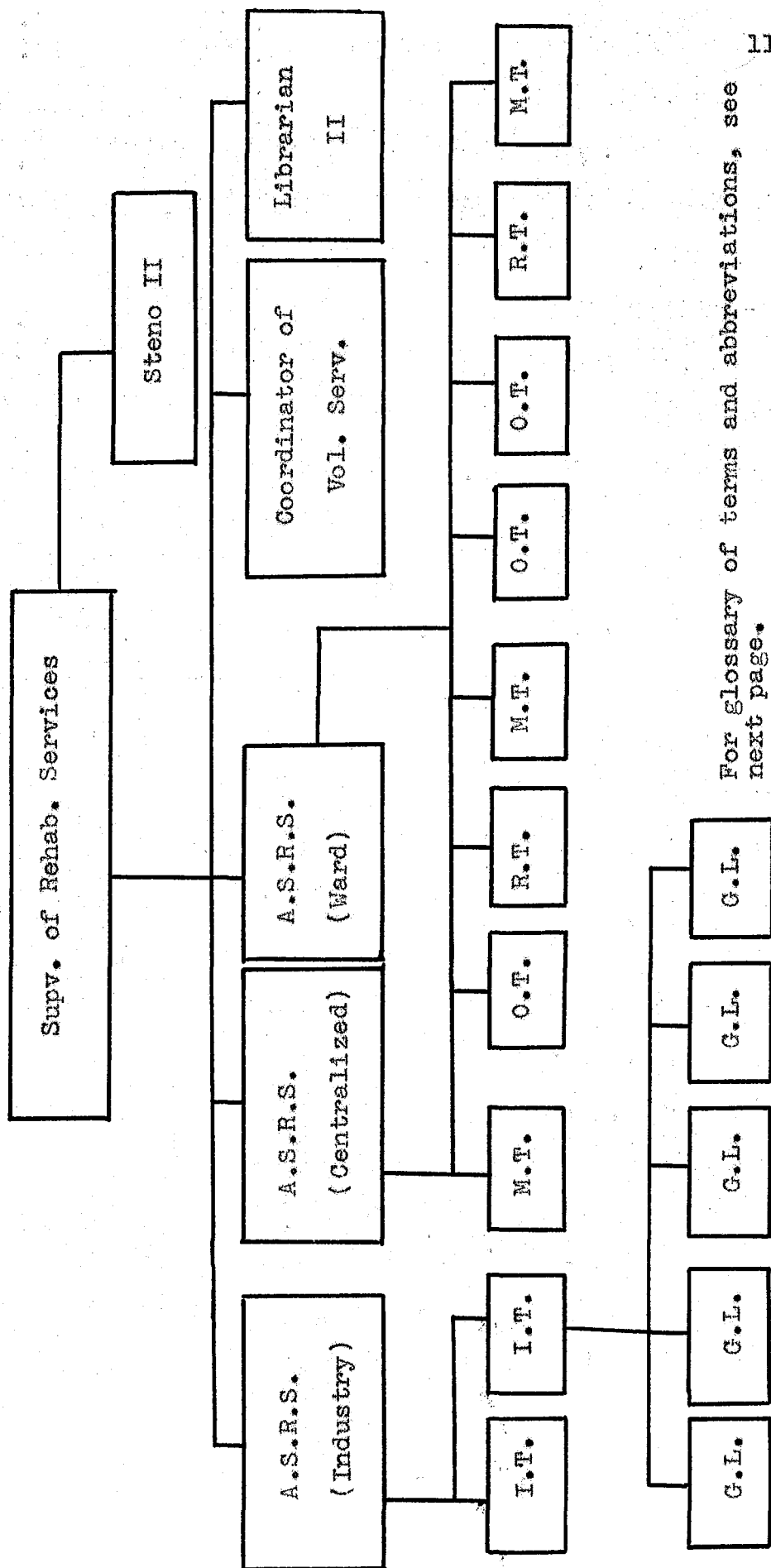
F. SPECIAL DAYS

BIRTHDAY	The Kindergarten Book, p. 72.	For non-ambulatory children have large picture of birthday cake on flannel board. Add honored child's name and correct number of candles. Young Mentally Retarded, Deaf or Ambulatory Handicapped children form a circle with honored child in center; others walk around singing. Use recording from Album K, <u>Our Singing World</u> .
Happy Birthday		

SONG TITLE	SOURCE	WAYS OF PRESENTATION AND USE
CHRISTMAS		DRAMATIZATION
Away in a Manger	The Kindergarten Book, p. 80. The First Grade Book, p. 92. Music in the Air, p. 64.	
Greeting Song	The Kindergarten Book, p. 82.	Use flannel board and pictures appropriate to Christmas; each child has a turn selecting another child's name and placing it on board.
Jingle Bells	The Kindergarten Book, p. 82. The First Grade Book, p. 99. Music in the Air, p. 226.	USE INSTRUMENTS. Ambulatory children march around Christmas tree singing.
Mary Had a Baby	American Folk Songs for Children, p. 180.	IMPROVISATION. Add verses about the Christmas story.
Silent Night	The Kindergarten Book, p. 81. The First Grade Book, p. 95. Happy Singing, p. 96.	
HALLOWEEN	Singing Fun	FINGER PLAY
Three Little Pumpkins		

SONG TITLE	SOURCE	WAYS OF PRESENTATION AND USE
<u>G. TRANSPORTATION</u>		
THE BUS	Singing On Our Way, p. 153. Singing and Rhyming, p. 10.	DRAMATIZATION. All groups, especially Mentally Retarded. Play recording of "The Bus" in Album 2A, <u>Our Singing World</u> .
THE TRAIN IS A-COMING	American Folk Songs for Children, p. 150.	ALL GROUPS. Younger children sing only "oh, yes." Older children sing entire song. This song is good for rhythmic play with ambulatory groups. Descriptive sounds of a whistle, wheels and engine may be added.

Schematic Table of Organization of Rehabilitation Services

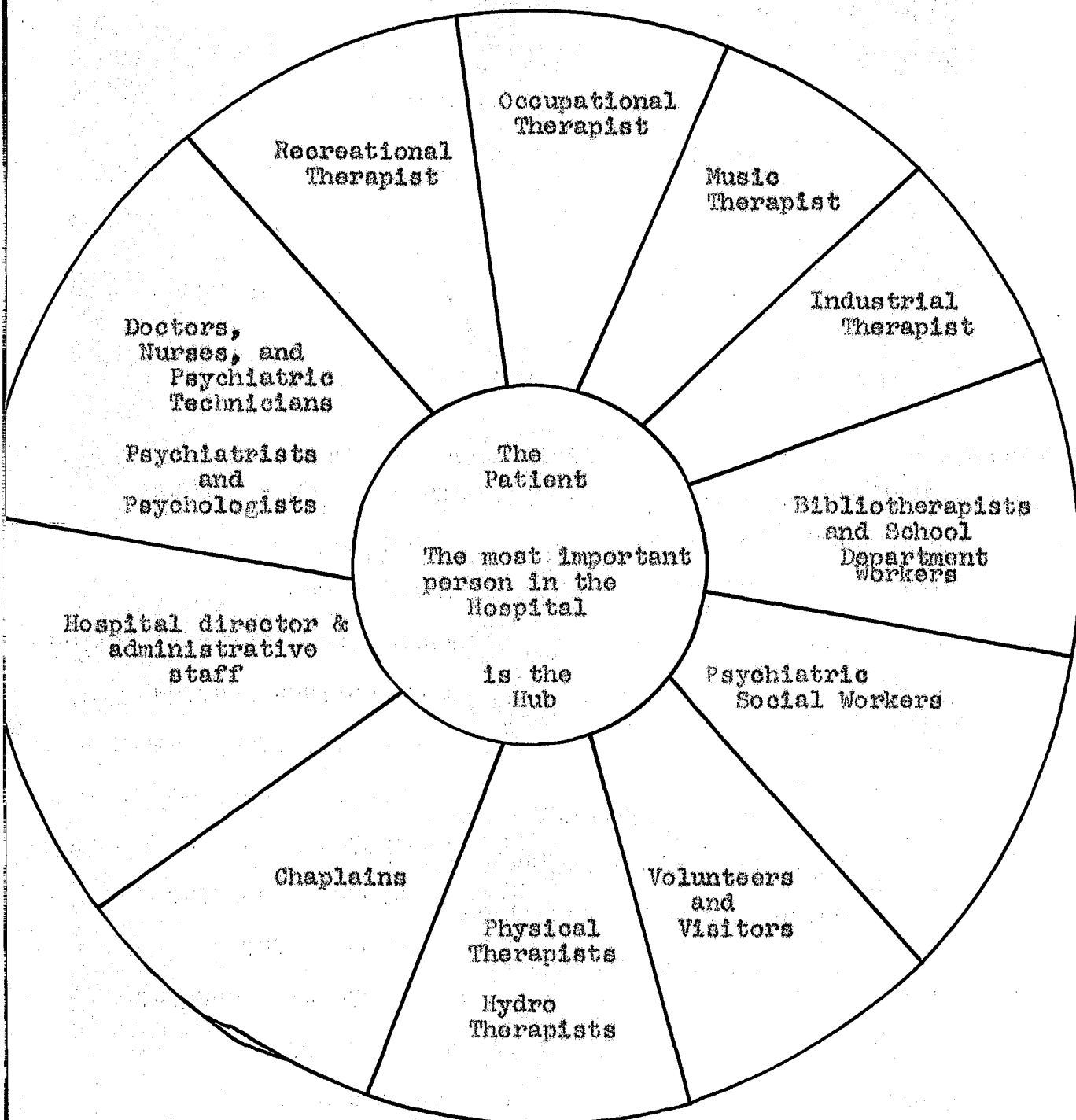


APPENDIX B, (Continued)

GLOSSARY OF TERMS AND ABBREVIATIONS

Supv.	Supervisor
Rehab.	Rehabilitation
O.T.	Occupational Therapist
M.T.	Music Therapist
I.T.	Industrial Therapist
R.T.	Recreation Therapist
A.S.R.S.	Assistant Supervisor of Rehabilitation Therapies
Ward	Ward Services Section
Centralized	Centralized Services Section
G.L.	Group Leader
Vol. Serv.	Volunteer Services
Steno.	Stenographer - typist

APPENDIX C



Wheel of Forces in Patient Therapy